

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10977

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 1601 Columbia Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard Kyle Alderson	4. DATE OF DEATH October 24 19 57	5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH November 15, 1951 9. AGE (in years last birthday) 5 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Kyle Henry Alderson, Jr.		14. MOTHER'S MAIDEN NAME Joyce Marlene Unzicker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Kyle Alderson; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351x Marasmus DUE TO (b) Cerebral palsy, congenital. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 25, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Oct. 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO.		24a. REC'D BY REGISTRAR 517 11th St. S.E., Wash., D.C.	24b. REGISTRAR'S SIGNATURE Oct 28 57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
DEPT.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Trance Service	
Sex		Cemetery	
Race		Place of Birth	
Date of Birth		Place of Death	
Cause of Death		Manner of Death	
Medical History		Other History	
Signature of Medical Examiner		Signature of Coroner	
Date		Place	

BUREAU V. S.

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10978

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. LENGTH OF STAY IN 1b 18 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4017 Webster Street		d. STREET ADDRESS 4017 Webster	
3. NAME OF DECEASED (Type or print) First John Middle Raymond Last Allen		4. DATE OF DEATH Month October Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-01
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace W. Allen		14. MOTHER'S MAIDEN NAME Ellen Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary M. Allen; 1602 N. Bryant St., Arlington, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH Va.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 21, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-24-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons		ADDRESS 447 N St. N.W. Wash	
24a. REC'D BY REGISTRAR Oct 23 '57		24b. REGISTRAR'S SIGNATURE Debra Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral home. Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 23 1957
BUREAU V. 2

John T. Williams, Jr.
1000 N. Broadway St., Baltimore, Md.

Acute congestive heart failure
Cardiovascular renal disease

John T. Williams, Jr.

10-8-57

John T. Williams, Jr.

John T. Williams, Jr.

John T. Williams, Jr.

John T. Williams, Jr.

John T. Williams, Jr.

John T. Williams, Jr.

John T. Williams, Jr.

John T. Williams, Jr.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10989 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
Item 9 FilmG222 11-6-57 et
CERTIFICATE OF DEATH

10979

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS Rt 2 Box 178			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Juanita Middle Allen Last Allen				4. DATE OF DEATH Month Oct. Day 31 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-19	
9. AGE (In years (last birthday)) 37 39 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 57		IF UNDER 24 HRS. Months 3 Days 19 Hours 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Chapman				14. MOTHER'S MAIDEN NAME Maude Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Leroy Chapman				Address Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra Ventricular Hemorrhage 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive A.S. Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 10-31 , 19 57 , to 10-31 , 19 57 , that I last saw the deceased alive on 10-31 , 19 57 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S. Fleischer M.D.				ADDRESS (Street, city or town, state) 1432 QUEENS CHAPEL Rd DATE SIGNED 11/1/57			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11.5.57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire				ADDRESS 1820 9th St., N.W.			
DATE NOV 4 '57				24b. REGISTRAR'S SIGNATURE Robert G. McGuire			
Washington, D.C.							

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1894

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1849		New York		New York		Heart Disease		Jan 15, 1900		10:00 AM		New York		J. Doe		J. Doe	
Occupation		Married		Color		Race		Religion		Education		Previous Illness		Manner of Death		Buried		Burial Place		Burial Date		Burial Time	
Teacher		Yes		White		Caucasian		Roman Catholic		High School		None		Natural		Yes		St. Mary's		Jan 15, 1900		10:00 AM	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Jury		Signature of Witnesses		Signature of Undertaker		Signature of Burial Society		Signature of Cemetery		Signature of Church		Signature of Minister	
None		None		None		None		None		None		None		None		None		None		None		None	

RECEIVED
NOV 4 1957
BUREAU V. S.

10:

FOR STATE
HEALTH DEPT.

Item 3 Film 0224 1/23/58 GTE

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 3563 55th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William Marcellus Anthony			4. DATE OF DEATH Month October Day 25 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-29	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY wrapping machines		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Harry Anthony		
14. MOTHER'S MAIDEN NAME Cora Stout			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes -marines-1953		
16. SOCIAL SECURITY NO. 226-36-7597			17. INFORMANT Julian Williams, 6227 Akron Street, Wash., D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of abdomen DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person.			
20c. TIME OF INJURY Month, Day, Year Hour 10-25- 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Bladensburg		20g. (County) Pr. Geo.		20h. (State) Nd.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED October 25, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORY Henderson Cemetery Hyattsville Md	
22d. LOCATION (City, town, or county) Hyattsville Md		22e. (State) Md		23. FUNERAL DIRECTOR'S SIGNATURE F. Busch's Sons Hyattsville Md	
24a. REC'D BY REGISTRAR Oct 28 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith			

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

Oct 28 1957

BUREAU V. 2

10-27-57

Spec is another person.

XXXXXXXXXX (typed name of subject)

XXXXXXXXXX and other XXXXXXXXXXXX

10-27-57

100-36-7507

Gold Bonds

XXXXXXXXXX XXXXXXXXXXXX Virginia

XXXXXXXXXX

XXXXXXXXXX

XXXXXXXXXX

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XXXXXXXXXX XXXXXXXXXXXX

XXXXXXXXXX XXXXXXXXXXXX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

11053

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1098134

1. PLACE OF DEATH o. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs x2 d. STREET ADDRESS 10- Armand Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last APPICH		4. DATE OF DEATH Oct. 9th. 19 57 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20- 1877 9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lumber Firm	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Appich		14. MOTHER'S MAIDEN NAME Louise Ermold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Furling B. Appich		Address 23, DO 10-Armand Ave., S. E. Wash.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 39 Acute congestive failure, at & left DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Januz, 1956, to Oct 9, 1957, that I last saw the deceased alive on October 9, 1957, and that death occurred at 4:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ernest E. Cornelsen M.D. 4400- Bowen Road S.E. Oct. 9th. 1957 PHYSICIAN'S NAME (Type) ERNEST E. CORNELSEN Washington 27, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 11- 57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661 1/2 Good Hope Road SE Washington 20, D.C.		24a. REC'D BY REGISTRAR DATE 11 1957 24b. REGISTRAR'S SIGNATURE Carrie Campbell	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
John Doe		Male		45		White		Teacher		Baltimore, Md.		Jan 1, 1900		Jan 1, 1957		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	

BUREAU V. R.
RECEIVED
OCT 11 1957

10991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL DANIEL ARNOLD</u>				4. DATE OF DEATH Month Day Year <u>OCT. 29 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/11/1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer Pressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Great Br</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>WIFE</u> Address <u>Evelyn M Arnold - Lanham Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>OCT 29</u> , 1957, to <u>OCT 29</u> , 1957, that I last saw the deceased alive on <u>OCT 29</u> , 1957, and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>10/29/57</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>				M.D. <u>MT PAINIER MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10093

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1912		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		High School		Married		1957		BALTIMORE		MD		USA			
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY			
Heart Disease		Natural		10/4/57		BALTIMORE		MD		USA					
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY			
J. H. Harris		J. H. Harris		10/4/57		BALTIMORE		MD		USA					

BUREAU V. 4

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10992

CERTIFICATE OF DEATH

10983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 11 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups				13 X 2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Annapolis Jct. Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lorraine Chaney Arthur				4. DATE OF DEATH Month Oct. Day 29 Year 19 57			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William H. Chaney				14. MOTHER'S MAIDEN NAME Hanna Thornton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ?		17. INFORMANT Clarence Chaney, Baltimore, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Failure. 154 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subarculo sis R the adrenal gland. (c) Adeno carcinoma to the testis.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/18 , 19 57 , to 10/29 , 19 57 , that I last saw the deceased alive on 10/29 , 19 57 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Comeau				ADDRESS (Street, city or town, state) 3503 Pennys T			
DATE SIGNED 10/29/57							
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU M.D.				MT PAINIER MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-57		22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Jessups, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE 1 57			
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Filed 10-11-57 et

CERTIFICATE OF DEATH

10984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown, Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown, Mt. Rainier x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3319 Chauncey Place		d. STREET ADDRESS 3319 Chauncey Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Barbara Bachman		4. DATE OF DEATH October 5th 1954	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1912
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Safeway Stores	
11. BIRTHPLACE (State or foreign country) Jamestown, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Neal McKenney		14. MOTHER'S MAIDEN NAME Josephine Brigman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 165-14-9987	
17. INFORMANT Address above		Harold L. Bachman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary insufficiency DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH immediate 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 3, 1954, to Oct. 5, 1957, that I last saw the deceased alive on Oct. 5, 1957, and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Frank R. Shea		M.D. 4100-22nd St E Wash DC 10/5/57	
PHYSICIAN'S NAME (Type) FRANK R. SHEA, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/8/57	22c. NAME OF CEMETERY OR CREMATORY Norwood Cem	22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Mt. Rainier, Inc.		ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE SET 9 1957		James Henry	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Oct 8, 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		MARITAL STATUS <i>Married</i>	
PLACE OF BIRTH <i>Wyoming</i>		PLACE OF DEATH <i>Wyoming</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>	
FUNDAMENTAL CAUSE <i>Atherosclerosis</i>		PRE-EXISTING DISEASES <i>Hypertension</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE <i>Oct 8, 1957</i>		PLACE <i>Wyoming</i>	

BUREAU V. S.

OCT 9 1957

RECEIVED

10993

CERTIFICATE OF DEATH

10985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>1 Day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Ceder Hgts,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>914 65th Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alfonzo</u> Middle <u>Bailey</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 57</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>2</u> Days <u>8</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. yrs. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u></u>				14. MOTHER'S MAIDEN NAME <u>Killian Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>914 65th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>772.0</u> DUE TO <u>Pulmonary Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)		
21. I certify that I attended the deceased from <u>Oct. 30, 1957</u> , to <u>Oct. 30, 1957</u> , that I last saw the deceased alive on <u>Oct. 30, 1957</u> , and that death occurred at <u>6:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Parkin</u> M.D.				ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville 14/31/57</u>			
PHYSICIAN'S NAME (Type) <u></u>				DATE SIGNED <u>10/31/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-4-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u> ADDRESS <u>467 N. St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

2077260XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

RECEIVED

BUREAU V. S.

NOV 6 1957

10994

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 27 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS Botler Lane			
3. NAME OF DECEASED (Type or print) First Sam Middle Strother Last Bailey				4. DATE OF DEATH Month October Day 12 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 20, 1886	
9. AGE (In years last birthday) yrs. 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME James Bailey			
14. MOTHER'S MAIDEN NAME Sallie Dwyer				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Cova Bailey Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 792x Mnesia, cause unknown DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Pneumonia, cause unknown DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 1, 1957 , to Oct 12, 1957 , that I last saw the deceased alive on Oct 12, 1957 , and that death occurred at 6:40 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnold Lear				ADDRESS (Street, city or town, state) 805 Sheridan St Hyattsville, Md			
NAME (Type) Dr. Arnold Lear				DATE SIGNED 10-13-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/57		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Culpeper Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.			
24a. REC'D BY REGISTRAR OCT 14 '57				24b. REGISTRAR'S SIGNATURE W. Beach			

RECEIVED

OCT 14 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10995 Item 12 Film G221 10-14-57 et
 CERTIFICATE OF DEATH

10987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 27 D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AGNES Middle Crawford Last BAILLIE				4. DATE OF DEATH Month OCTOBER Day 7 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 12, 1870	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Crawford				14. MOTHER'S MAIDEN NAME Agnes Mc Kendrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Allan S. Baillie Address 2200-53 Ave Wash. 27 DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branch pneumonia & pt. Cerebral edema DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Hb disease DUE TO (c) Arterio-sclerotic Hb disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.7 INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-1-57 , 19 57 , to 10-7 , 19 57 , that I last saw the deceased alive on 10-7-57 , and that death occurred at 9:40 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE John T. Lyman				ADDRESS (Street, city or town, state) 5241 E. Barnard Rd 21 DC			
PHYSICIAN'S NAME (Type) John T. Lyman				DATE SIGNED 10/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/57		22c. NAME OF CEMETERY OR CREMATORY Fort Stenben Estates		22d. LOCATION (City, town, or county) (State) Stenbenville Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR 5 24b. REGISTRAR'S SIGNATURE W.W. Chambers			
ADDRESS 517 11th St E.				DATE OCT 7 1957			

CERTIFICATE OF DEATH

DECEASED

WASHINGTON

1900 - 1901

DECEASED

1901 - 1902

DECEASED

1902 - 1903

DECEASED

1903 - 1904

DECEASED

1904 - 1905

DECEASED

1905 - 1906

DECEASED

1906 - 1907

DECEASED

1907 - 1908

DECEASED

1908 - 1909

DECEASED

BUREAU V. B.

OCT 9 1957

RECEIVED

10975

CERTIFICATE OF DEATH

10988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3924 Oliver Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville Maryland			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 3924 Oliver Street			
3. NAME OF DECEASED (Type or print) First Middle Last Lillian R. Barr				4. DATE OF DEATH Month Day Year Oct 23, 1957. 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 25, 1903	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James H. Moxley				14. MOTHER'S MAIDEN NAME Dora Hoffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Charles A Barr Sr Hyattsville, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ovary generalized 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of ovary DUE TO (c) 16 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspirin							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cottage City, Md.				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 4, 1955 to Oct 23, 1957 , that I last saw the deceased alive on 10/22, 1957 , and that death occurred at 4:58 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717-3 Rd Le DATE SIGNED 10-23-57 ACTUAL SIGNATURE George Hageage M.D. George Hageage PHYSICIAN'S NAME (Type) George Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/57		22c. NAME OF CEMETERY OR INTERMENT PLACE Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24. REGISTRATION DATE OCT 28 1957 24b. REGISTRAR'S SIGNATURE James Severey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

28 OCT 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10989

10996

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <i>The Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>same as #1</i> COUNTY <i>as #1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>25 same as #1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6314 Tuckerman</i>		d. STREET ADDRESS <i>same as #1</i>	
3. NAME OF DECEASED (Type or print) <i>ORLO</i> First <i>all</i> Middle <i>BARTHOLOMEW</i> Last		4. DATE OF DEATH <i>Oct 22 1957</i> Month <i>Oct</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5 June 1891</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Land Engineer</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Land Engineer</i>		10b. BIRTHPLACE (State or foreign country) <i>Germany</i>	
11. FATHER'S NAME <i>Charles S. Bartholomew</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Charles S. Bartholomew</i>		14. MOTHER'S MAIDEN NAME <i>Ella Henderson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes WWI</i>		16. SOCIAL SECURITY NO. <i>149229548</i>	
17. INFORMANT <i>Bertha Bartholomew</i>		Address <i>Danvers #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive cardio-vascular disease</i> DUE TO (c) <i>disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1953</i> to <i>Oct 1957</i> , that I last saw the deceased alive on <i>Sept 27 1957</i> , and that death occurred at <i>5 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.C. Etienne</i>		DATE SIGNED <i>10/23/57</i>	
PHYSICIAN'S NAME (Type) <i>W.C. ETIENNE</i>		ADDRESS (Street, city or town, state) <i>4713 - Bepany Rd College Park, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>25 Oct 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland</i>	
24. RECD BY REGISTRAR <i>DATE 24 1957</i>		24b. REGISTRAR'S SIGNATURE <i>James E. Lavery</i>	

ET

24. 1957

BUREAU V. 81

RECEIVED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Maryland Park			
3. NAME OF DECEASED (Type or print) Carrie May Basler				d. STREET ADDRESS 101-64th Street			
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female				6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH Oct 16, 1957				9. AGE (in years last birthday) 77 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A				13. FATHER'S NAME James Harps			
14. MOTHER'S MAIDEN NAME Elizabeth James				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Margaret Catharine Tally same 60th			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Congestive heart fail DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Md.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR OCT 18 57	
24b. REGISTRAR'S SIGNATURE				DATE			

DATE SIGNED

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Oct 16, 1957

RECEIVED
OCT 18 1957
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11054 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY IN 1b 16 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1007 Maple Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Leo Baumann		4. DATE OF DEATH October 4, 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1909
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Baumann		14. MOTHER'S MAIDEN NAME Barbara Frieze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 579-48-6299	
17. INFORMANT Dorothy E. Baumann;		Address same address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Oct 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR OCT 7 1957	
24b. REGISTRAR'S SIGNATURE Agnes Young			

MEDICAL CERTIFICATION

STATE OF
DEATH CERTIFICATE

DATE OF DEATH

Howie

1007 Maple Avenue

John

White

30

Engineer

Other

77-8-333

acute congestive heart failure

Coronary atherosclerosis

BUREAU V. 8

OCT 7 1957

RECEIVED

October 1, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10976

Item 7 Film G221 10-22-57 et
CERTIFICATE OF DEATH

10992
2/5

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 6010 44th. Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Wilson Birch		4. DATE OF DEATH Month Day Year Oct. 13th. 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1868
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Wilson		14. MOTHER'S MAIDEN NAME Henrietta Baldwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Daughter		Address 6010 44th. Ave., Hyattsville, 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Hypertensive Cordia Nucleus Primus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 104 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age 89			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947, to 10-13, 1957, that I last saw the deceased alive on 10-12, 1957, and that death occurred at P.M. AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Waldo B. Moyers M.D. 3503 Perry St. Mt. Rainier, Md. 10-13-57			
PHYSICIAN'S NAME (Type) Waldo B. Moyers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/57	
22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Birch's Sons		ADDRESS 3034 M St., N.W., D.C.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE James Seavey	
DATE OCT 15 1957			

0501

BUREAU V. S.

OCT 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG222 11-4-57 et

CERTIFICATE OF DEATH

109934/2

Reg. Dist. No.

11055

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forrestville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forrestville</u>		c. LENGTH OF STAY IN 1b <u>Forrestville</u>		d. STREET ADDRESS <u>5294 Forrestville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Adelaide</u> Middle <u>D</u> Last <u>Bohrer</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 15, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>19</u> Hours <u>57</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Alexander C.H. Darne</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Darby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Ruth D'Butts</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> <u>442x</u> DUE TO <u>hypertensive C.V.R</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diarrhea</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1, 1945</u> , to <u>Oct 24, 1957</u> , that I last saw the deceased alive on <u>Oct 24, 1957</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin M.D.</u>				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>10/24/57</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>26 Oct 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cem. Herndon, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 4th + Main ave NE</u>				ADDRESS <u>WASH. D.C.</u>			
24a. REC'D BY REGISTRAR <u>OCT 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar.

CERTIFICATE OF DEATH

1955

NAME OF DECEASED George		SEX Male		AGE 65	
DATE OF BIRTH 1890		PLACE OF BIRTH Maryland		RACE White	
OCCUPATION Retired		EDUCATION High School		MARRIAGE Married	
DATE OF DEATH 1955		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease	
DATE OF INTERVIEW 1955		PLACE OF INTERVIEW Home		INTERVIEWER Dr. Smith	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

OCT 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10998

CERTIFICATE OF DEATH

10994

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 24 Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond O. Boniff		4. DATE OF DEATH Month Day Year 10 9 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Mar 1912
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPUTY Collector		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) SPARTA, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. BORIFF		14. MOTHER'S MAIDEN NAME SARAH A. WEAVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 499-14-0286	
17. INFORMANT WILLIAM H. BORIFF		Address 3817 Oglethorpe St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 690.3 DUE TO acute Septicemia (b) Cardio- left elbow (c) Marked creatinemia due to old polio DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 days. 1 week 45 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-6, 1957, to 10-9, 1957, that I last saw the deceased alive on 10-9, 1957, and that death occurred at 12:57 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D. Bauer, M.D.		ADDRESS (Street, city or town, state) 2513 Buckhage Rd. Adelphi, Md.	
DATE SIGNED 10/9/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY The Weaver Cemetery		22d. LOCATION (City, town, or county) (State) Ozark, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Chambers		24a. REG. BY REGISTRAR R. D. Bauer	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

BUREAU V. 1

OCT 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10995

11056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>775 Columbia Rd., N. W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>—</u> Last <u>Braswell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/24/41</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charlie R. Braswell</u>				14. MOTHER'S MAIDEN NAME <u>Mallie Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Charlie R. Braswell</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUDDEN DEATH, POSTOPERATIVE, FOLLOWING RT. UPPER LOBECTOMY & WEDGE RESECTION SUPERIOR SEGMENT</u> DUE TO <u>RT. LOWER LOBE 9/30/57, CAUSE UNDET.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS 7 mos. (REASON FOR SURGERY)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19 57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>57</u> , to <u>10/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/14</u> , 19 <u>57</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>10/14/57</u>							
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u>				PHYSICIAN'S NAME (Type) <u>Moe Weiss, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>10/15/57</u>		<u>Arlington Nat'l. Cemetery</u>		<u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. F. Taylor</u>				ADDRESS <u>Funeral Home 1702-H/2nd</u>		24a. REC'D BY REGISTRAR DATE <u>5 OCT 17 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. F. Leach</u>							

BUREAU V. S.

OCT 17 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

11057

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>		c. LENGTH OF STAY IN TB <u>45 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u> X1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mill Branch Road</u>				d. STREET ADDRESS <u>Mill Branch Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Heinrich</u> Middle <u>Brothner</u> Last <u>Brothner</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gun farm</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>German</u>	
13. FATHER'S NAME <u>Heinrich Brothner</u>				14. MOTHER'S MAIDEN NAME <u>Kreuzberg Brothner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Henry John Brothner, same as #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>White Marsh, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. P. Young</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 1 1957

RECEIVED

11059

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Lanyard Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lanyard Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marvin Leo Brown</u>				4. DATE OF DEATH <u>Oct 24 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16 1957</u>	
9. AGE (In years last birthday) <u>2</u> yrs. <u>8</u> months <u>8</u> days		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Edward Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lucille Mahle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>John E. Brown, same as #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James L. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James L. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Retus</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home Waldorf, Md</u>				24a. REC'D BY REGISTRAR <u>10/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. [unclear]</u>	
				DATE <u>Oct 28 1957</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2077254XV3

RECEIVED

10999

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>		c. LENGTH OF STAY IN 1b <u>2 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>405-58th Street</u>				d. STREET ADDRESS <u>1 405-58th</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1885</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Clifton Hardy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Alice Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William Roy Brown</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 29, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington, Natl. Suitland, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 1 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 1 1957

RECEIVED

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 , 11059
 CERTIFICATE OF DEATH

10999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie				c. LENGTH OF STAY IN 1b 18 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's County Rest Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle -- Last Butlern				4. DATE OF DEATH Month October Day 17, Year 19 57.			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Empl'd Gardiner		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Alfred H. Smith- Blythwood Farm, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis arteriosclerotic</u> DUE TO (c) <u>General arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 1, 1956 to Oct 17, 1957, that I last saw the deceased alive on Oct 16, 1957, and that death occurred at 9 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5440 Silver Hill Road, 10/17/57: Suitland, Maryland.							
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D.				DATE SIGNED 10/17/57			
PHYSICIAN'S NAME (Type) Paul C. Van Natta, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem:		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE 10/21/57	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

BUREAU V. S.

1957 21 JUL

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10983

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier	
c. LENGTH OF STAY IN 1b 34 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3813 33rd Street		d. STREET ADDRESS 3813 33rd Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Susan Camfield		4. DATE OF DEATH October 5 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1881
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Marson		14. MOTHER'S MAIDEN NAME Margaret Krock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Thornton J. Camfield; Address same address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial asthma.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John J. Maloney M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) John T. Maloney, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	October 5, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/8/57	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
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23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home	ADDRESS Mt. Rainier Md.	24a. REC'D BY REGISTRAR 9	24b. REGISTRAR'S SIGNATURE James Devereaux
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RECEIVED

OCT 9 1957

BUREAU V. 5

hypertensive cardiovascular disease

Theodore J. Gendrich; same address

Kayser, Brock

Wichman

April 3, 1957

order

2000 10th Street

Robert Rainier

34 years

Robert Rainier

2013 10th Street

white

Male

Nicholas Wilson

No

Investigation set at

11000

CERTIFICATE OF DEATH

11001

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>1917- 17th. Street S. E.</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>CAPONITI</u> Middle Last		4. DATE OF DEATH <u>Oct. 3rd.</u> Month Day Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10- 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Natale Caponiti</u>		14. MOTHER'S MAIDEN NAME <u>Domenica Cascio</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James G. Caponiti</u>		Address <u>1624- Good Hope Rd. S. E. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>377x Necrotizing Papillitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>360x Etiology unknown</u> (b) <u>Etiology unknown</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/26</u> , 19 <u>57</u> , to <u>10/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/3/57</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon R. Levitsky</u> M.D.		ADDRESS (Street, city or town, state) <u>3408 Rhode Island</u> DATE SIGNED <u>10/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>		<u>M. Rainick, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 7th 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>		24a. REC'D BY REGISTRAR <u>1661- Good Hope Road SE Washington, D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>DATE OCT 7 57</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES G. GORDON		Male		35		1922-03-15	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Police Officer		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
1957-10-27		Baltimore, Md.		1957-10-29		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11002 237

11001

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>	c. LENGTH OF STAY IN 1b <u>2 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Seat Pleasant</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6211- Kingston Ave</u>		d. STREET ADDRESS <u>64th Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>(Joseph)</u> Middle <u>Bernard</u> Last <u>Carroll</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 7 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 MRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Carroll</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Hood</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>579-40-4580</u>		17. INFORMANT <u>Rose McDonald, same as #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Congestive heart failure</u> DUE TO (b) <u>Sluggish Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James L. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES L. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-4-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>OCT 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11003

Reg. Dist. No.

11002

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 8101 Park Blvd.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Cave			4. DATE OF DEATH Month Day Year October 10, 19 57				
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/57		9. AGE (In years last birthday) yrs. 1 15		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William David Cave				14. MOTHER'S MAIDEN NAME Erna Asmussen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Md her		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Bilateral atelectasis DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 min 1 hr 15 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10/57 , 19 57 , to 10/10/57 , 19 57 , that I last saw the deceased alive on 10/10/57 , 19 57 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Sasser				M.D. Yppr M... Oct 10-57			
PHYSICIAN'S NAME (Type) R. B. Sasser				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/29/57		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Wenn, Jr., Administrator				24a. REC'D BY REGISTRAR NOV 1 57		24b. REGISTRAR'S SIGNATURE	

2077253XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11003

CERTIFICATE OF DEATH

11004

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u>		d. STREET ADDRESS <u>#5 5th St. Cherry Hill Trailer Court</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Gouverneur, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ambrose Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Helen Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mahel C. Jewell, (same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>10 yrs.</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>55</u> , to <u>10-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-28</u> , 19 <u>57</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. D. Baker</u>		M.D. <u>2513 Buck Lodge Rd.</u>	
PHYSICIAN'S NAME (Type) <u>R. D. BAKER, M.D.</u>		ADDRESS (Street, city or town, state) <u>College Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>Oct. 31, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Antwerp Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Antwerp New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. L. Jones</u>		ADDRESS <u>WASH. D.C. 254 CARROLL ST. N.W.</u>	
24a. REC'D BY REGISTRAR <u>Jones</u>		24b. REGISTRAR'S SIGNATURE <u>Jones</u>	
DATE <u>OCT 30 1957</u>			

BUREAU V. 3

OCT 30 1957

RECEIVED

11050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1814 Que St., S.E., #10	
3. NAME OF DECEASED (Type or print) Bessie J. Cleary		4. DATE OF DEATH Month 10 Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/1900
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bindery Operator	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Mann		14. MOTHER'S MAIDEN NAME Nettie Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis due to arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus 260x Pneumonia left lung; etiology undetermined; pulmonary tuberculosis; 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20c. TIME OF INJURY Hour a. j. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21 , 19 57 , to 10/24 , 19 57 , that I last saw the deceased alive on 10/24/57 , and that death occurred at 4:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		DATE SIGNED 10/24/57	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale Hospital Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 1957	
22c. NAME OF CEMETERY OR CREMATORY Glenn Dale Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley Funeral Home		24a. REC'D BY REGISTRAR DATE OCT 28 '57	
ADDRESS 2847 Wisconsin Blvd		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11061

CERTIFICATE OF DEATH

11007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILL CREST HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILL CREST HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>5800 ARMORE PLACE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL V. COLEMAN</u>				4. DATE OF DEATH Month Day Year <u>OCT 28, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 29 1896</u>	
9. AGE (In years lost by days) <u>61</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gun Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ANDREW J. COLEMAN</u>			
14. MOTHER'S MAIDEN NAME <u>JOLLETTE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>MRS EVELYN COLEMAN Res</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>7-20-1953</u> to <u>10-28, 1957</u> that I last saw the deceased alive on <u>10-28-1957</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D. <u>5731 23rd Parkway S.E. 1028</u>				DATE SIGNED <u>Nov. 21, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>5731 23rd PARKWAY S.E.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-31-57</u>			
22b. DATE THEREOF <u>10-31-57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>			
22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Persson</u> ADDRESS <u>300-48 D.C.</u>			
24a. REC'D BY REGISTRAR <u>OCT 30 '57</u>				24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1912</i></p>	
<p>5. PLACE OF BIRTH <i>Washington, D.C.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1935</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Oct 30 1957</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>Dr. J. Smith</i></p>	

BUREAU V. S.

OCT 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11062 CERTIFICATE OF DEATH

1100847
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 SEAT PLEASANT</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>16446 ROLLINS AVE</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLOTTE E COMPTON</u>				4. DATE OF DEATH <u>OCT 1 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-1900</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Correll</u>				14. MOTHER'S MAIDEN NAME <u>Freda Siebert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Charles C Compton</u> Address <u>6446 Rollins Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO <u>Severe Hypertensive Arteriosclerotic Heartdisease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heartdisease</u> DUE TO (c) <u>Heartdisease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>12 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Very Severe Hypertensive 300+/140.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952 Jan</u> 19 <u>—</u> to <u>10/1/57</u> 19 <u>—</u> , that I last saw the deceased alive on <u>10/1/57</u> 19 <u>—</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney W. Lowry</u>				ADDRESS (Street, city or town, state) <u>7200 Wareboro Pike SE</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWRY M.D. District Heights, Md.</u>				DATE SIGNED <u>10/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-4-57</u>		<u>ADDISON CHAPEL</u>		<u>SEAT PLEASANT MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home 4812 24 Ave</u>				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

CERTIFICATE OF DEATH

1953

Page 012-14

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>10/15/1908</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>12/10/1935</i>	
9. NAME OF SPOUSE <i>John J. Smith</i>		10. DATE OF DEATH <i>10/15/1953</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
15. SIGNATURE OF DECEASED <i>John J. Smith</i>		16. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
17. SIGNATURE OF FUNERAL HOME <i>John J. Smith</i>		18. SIGNATURE OF BURIAL PLACE <i>John J. Smith</i>	
19. SIGNATURE OF COUNTY CLERK <i>John J. Smith</i>		20. SIGNATURE OF STATE CLERK <i>John J. Smith</i>	

BUREAU V. E.

OCT 2 1957

RECEIVED

11063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1100000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-WALDORF, MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCOTTEK 08 X 0.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) VERA SUSIE VERA COOK		4. DATE OF DEATH Month OCTOBER Day 22 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 5 1914
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT JENKIN		14. MOTHER'S MAIDEN NAME SUSIE BERRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WILLIAM COOK		Address ACCOTTEK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SURGICAL SHOCK 825X DUE TO (b) COMPOUND FRACTURE, RIGHT FEMUR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO ACCIDENT	
20c. TIME OF INJURY Month, Day, Year Hour 5:30 p.m. OCT. 22 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY	
20f. (City or town) P.G.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V. B. DETTOR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 23 Oct. 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-25-57	
22c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.		22d. LOCATION (City, town, or county) (State) ACCOTTEK, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDORF, MD.	
24a. REC'D BY REGISTRAR DATE 10/25/57		24b. REGISTRAR'S SIGNATURE Julia H. Hany	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

VERA

BUREAU V. S.

OCT 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11004

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathy Ann Cooper		4. DATE OF DEATH October 1, 19 57	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1957	
9. AGE (In years last birthday) 7 weeks		10. IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		12. KIND OF BUSINESS OR INDUSTRY *****	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Robert Cooper		16. MOTHER'S MAIDEN NAME Carol Crayne	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. Robert Cooper; same address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) (c), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial, Oct 3 1957		22b. DATE THEREOF Oct 3 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Hill		22d. LOCATION (City, town, or county) (State) Pr. Geo. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. ...		24a. REC'D BY REGISTRAR Oct 9 57	
24b. REGISTRAR'S SIGNATURE ...		DATE Oct 9 57	

2077223XV4

MISSOURI STATE DEPARTMENT OF HEALTH - BARNHART
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Deceased Name: Prince, George

Age: 70.00

Place of Birth: Prince Georges General Hospital

Date of Death: Aug. 10, 1957

Place of Death: Maryland

Sex: Male

Occupation: Robert Cooper; a no address

Signature

BUREAU V. 1

OCT 9 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11011
11005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 2906 Rueckart Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Archie Middle Grayson Last Crummitt			4. DATE OF DEATH Month October Day 13 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1898		9. AGE (In years, birth day) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY B.&O. Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Albert W. Crummitt			14. MOTHER'S MAIDEN NAME Mary Creager		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-0635		17. INFORMANT Address Elizabeth Crummitt; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 13, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
				22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR OCT 15 1957		
			24b. REGISTRAR'S SIGNATURE James Henry		

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John T. Malone, R.D.
RESIDENCE: 1000 Maryland Avenue
CITY: Baltimore
COUNTY: Harford
DATE OF DEATH: Sept. 27, 1957
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
AGE: 70
SEX: Male
RACE: White
RELIGION: Catholic
EDUCATION: High School
OCCUPATION: None
MARITAL STATUS: Married
SPOUSE: John T. Malone, R.D.
DECEASED'S SIGNATURE: _____
WITNESSES' SIGNATURES: _____
MEDICAL EXAMINER'S SIGNATURE: _____
MEDICAL EXAMINER'S TITLE: _____

100-10-105
Add: 1000 Maryland Avenue
City: Baltimore
County: Harford

BUREAU V. 3

OCT 15 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11006

CERTIFICATE OF DEATH

11012
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 308 Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Curley Last				4. DATE OF DEATH Month Oct. Day 20 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Williamsport, Md		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Philip P. Castle				14. MOTHER'S MAIDEN NAME Elmira Jane Puffengarger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 6 - - -		17. INFORMANT Address Mrs. Regina Hobbs St. Petersburg, Fla.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hyperlipidemia - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Cardio-Vascular Dis.						INTERVAL BETWEEN ONSET AND DEATH 4 d.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 to 10/20 , 19 57 , that I last saw the deceased alive on 10/20 , 19 57 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B P Warren M.D.				ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 10/21/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill		22d. LOCATION (City, town, or county) (State) Laurel, Md. P. G. Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. ...				ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 25 '57	
				24b. REGISTRAR'S SIGNATURE W. ...			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 8

OCT 25 1957

RECEIVED

11064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADBERRY PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADBERRY PARK X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4734 BROMLEY AVE				d. STREET ADDRESS 4734 BROMLEY AVE.			
3. NAME OF DECEASED (Type or print) First BERTHA Middle V. Last DECKER				4. DATE OF DEATH Month OCTOBER Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Henry Wright				14. MOTHER'S MAIDEN NAME Eva Stemb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 064-143904		17. INFORMANT Willard Vany - Bradberry Park Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 20 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August , 19 57 , to Oct 25 , 19 57 , that I last saw the deceased alive on Oct 25 , 19 57 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3112 - AIA AVE. SE. DATE SIGNED ACTUAL SIGNATURE J. H. Thibadeau M.D. PHYSICIAN'S NAME (Type) J. H. Thibadeau							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10-29-57		East Blomfield Cent.		East Blomfield N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee - Wash. D.C.				ADDRESS D.C.		24a. REC'D BY REGISTRAR DATE OCT 29 57	
				24b. REGISTRAR'S SIGNATURE W. H. Thibadeau			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

See Rev. 10-1-57

NAME OF DECEASED <i>WILLIAM J. BROWN</i>		AGE <i>68</i>	
SEX <i>M</i>		RACE <i>W</i>	
DATE OF BIRTH <i>1-15-1889</i>		PLACE OF BIRTH <i>MASSACHUSETTS</i>	
DATE OF DEATH <i>10-29-1957</i>		PLACE OF DEATH <i>BOSTON</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>11-5-1957</i>		DATE OF SIGNATURE <i>11-5-1957</i>	

BUREAU V. 8

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11014

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxon Hill</u>	c. LENGTH OF STAY IN 1b <u>54 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxon Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6650 Tucker Road</u>		d. STREET ADDRESS <u>16650 Tucker Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Edmonia</u> Last <u>Delaney</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C</u>	
13. FATHER'S NAME <u>Walter Marr</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Marr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Jennie E. Warrell</u>		Address <u>3020 Albemarle Rd, Wash 22, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 24, 1957</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial Oct 26-57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnations</u>	22d. LOCATION (City, town, or county) (State) <u>Coxon Hill, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
ADDRESS <u>1661 Good Hope Rd, Wash 20, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	
		DATE <u>Oct 28 1957</u>	

NATURAL EXAMINER'S CERTIFICATE OF DEATH

1-1003

RECEIVED
OCT 28 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11015
Item 4, Film G222, 11/1/57, fcy										24
10977										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD</u>					c. LENGTH OF STAY IN 1b <u>15</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS <u>6236 DARBEY RD.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN JOSEPH DOLAN</u>					4. DATE OF DEATH Month Day Year <u>October 27, 1957</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-8-76</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>MICHAEL DOLAN</u>					14. MOTHER'S MAIDEN NAME <u>MARY ROONEY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>MARY BENTON</u> Address <u>6736 DARBEY RD</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension from previous stroke 15 yrs ago</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>15 yrs</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 1957, to <u>25 Oct</u> , 1957, that I last saw the deceased alive on <u>25 Oct</u> , 1957, and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED										
ACTUAL SIGNATURE <u>John Kehoe</u> M.D. PHYSICIAN'S NAME (Type) <u>JOHN KEHOE, M.D.</u> <u>3404 CHEVERLY AVE.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>10-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Colvar Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New York NY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>					ADDRESS <u>4812 Ga archw D</u>		24a. REC'D BY REGISTRAR <u>20155</u>		24b. REGISTRAR'S SIGNATURE <u>James Severey</u>	

CERTIFICATE OF DEATH

BUREAU V. 1

OCT 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box. 284--Westphalia Rd.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Forestville			
f. STREET ADDRESS 1 Box 284 Westphalia Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle O. Last Douglass				4. DATE OF DEATH Month Oct. Day 20th. Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1873	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Phillip Collins				14. MOTHER'S MAIDEN NAME Mary E. Ensor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Lillian O. Anderson Box. 286 Westphalia Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA - Cerebral Vascular Accident 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer DUE TO (c) ASMO - Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/19, 1957, to 10/20, 1957, that I last saw the deceased alive on 10/20, 1957, and that death occurred at 11:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Oct. 21st. 1957							
ACTUAL SIGNATURE David R. Lenarduzzi M.D.							
PHYSICIAN'S NAME (Type) David R. Lenarduzzi				2901-Fairlawn Ave., SE Hillcrest Hgts, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23-1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				ADDRESS 1661--Good Hope Rd., SE Washington, DC		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
OCT 22 1957

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11017

11007

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant/ Cheverly				c. LENGTH OF STAY IN 1b 22 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Duchene/ Viola First May Middle Duchene Last				4. DATE OF DEATH Month Oct Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/03	
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months 1 Days 19 Hours 57		IF UNDER 24 HRS. Months 1 Days 19 Hours 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austine A. Adams				14. MOTHER'S MAIDEN NAME Grace Hart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. August A. Duchene		Address 7013 D St. S.E. Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension C.V.R. Disease DUE TO (c) Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 24 hours Myo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 15 , 19 56 to Oct 21 , 19 57 , that I last saw the deceased alive on Oct 21 , 19 57 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin				ADDRESS (Street, city or town, state) 6124 Central Ave Capitol Heights Md			
NAME (Type) WM BRAININ				DATE SIGNED 10/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517-11th St. S.E.		24a. REC'D BY REGISTRAR DATE OCT 24 '57	
24b. REGISTRAR'S SIGNATURE Reed							

BUREAU V. S.

OCT 24 1957

RECEIVED

10974

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md				c. LENGTH OF STAY IN 1b 14			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4720 Ruatan Street,.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude T. Dyer				4. DATE OF DEATH Month Day Year October 25, 19 57.			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 20, 1884		9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Katherine E. Dyer College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 20			
443X DUE TO Hypertensive Cardio-vascular				10 yr			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1949 19 to Oct 57 , that I last saw the deceased alive on October 19 57 , and that death occurred at 12 1/2 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. L. Etienne				ADDRESS (Street, city or town, state) 4713 - Tremont Rd College Park, Md			
PHYSICIAN'S NAME (Type) W. L. ETIENNE				DATE SIGNED 10-26-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE OCT 29 '57		24b. REGISTRAR'S SIGNATURE W. L. Etienne	

10

BUREAU V. 5

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11019

11008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL				d. STREET ADDRESS 7413 Maple Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DORA Middle C Last FERRIER				4. DATE OF DEATH Month 10 Day 19 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Oct 1917		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John N. Ours				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Joseph G. Ferrier (same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Intestinal Obstruction 174x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pelvic Carcinomatosis DUE TO (c) Adenocarcinoma uterus.						INTERVAL BETWEEN ONSET AND DEATH 1 month. 4 months. 4 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12 , 19 57 , to October 19 , 19 57 , that I last saw the deceased alive on October 19 , 19 57 , and that death occurred at 7:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Petris Gonzalez E.				ADDRESS (Street, city or town, state) Prince Georges General Hospital			
PHYSICIAN'S NAME (Type) Dr. George H Molain				DATE SIGNED 8-20-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Ch. George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				ADDRESS 254 Carroll St NW. DC.		24a. REC'D BY REGISTRAR DATE OCT 22 57	
				24b. REGISTRAR'S SIGNATURE W. L. Leach			

CERTIFICATE OF DEATH

11-30

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF OTHER					

BUREAU V. 8

OCT 22 1957

RECEIVED

11009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>3 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 Apr. 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Hotel Supply</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Emily Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>578-09-3505</u>			
17. INFORMANT <u>Mrs. Jessie F. Fisher</u>				Address <u>9199 Central Ave, Capitol Hts. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>57</u> , to <u>10/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>57</u> , and that death occurred at <u>2.00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ronald S. Fleischer</u> M.D.				ADDRESS (Street, city or town, state) <u>5432 QUEENS CHAPEL RD HYATTSVILLE, MD</u>			
DATE SIGNED <u>10/21/57</u>							
PHYSICIAN'S NAME (Type) <u>W. W. Chambers</u>				ADDRESS <u>517-11th St. S.E.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>10/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Southland Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				ADDRESS <u>517-11th St. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 24 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Overland</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 4500 Banner St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Ford Last Ford				4. DATE OF DEATH Month October Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-2- 1885	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Norbeck Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Ford				14. MOTHER'S MAIDEN NAME Althea Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Amanda Bond- Silver Spring, Md. Route # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular mal-drawn (c) Patel c. b. s.				INTERVAL BETWEEN ONSET AND DEATH 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-8 , 19 57 , to 10/23 , 19 57 , that I last saw the deceased alive on 10/23 , 19 57 , and that death occurred at 8:00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S Fleischer M.D.				ADDRESS (Street, city or town, state) 5432 QUEENS CHAPEL Rd HYATTSVILLE MD			
DATE SIGNED 10/27/57							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Buried				10/27/57		Norbeck Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L Shoulen				ADDRESS Rockville		24a. REC'D BY REGISTRAR DATE OCT 31 57	
				24b. REGISTRAR'S SIGNATURE Althea			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
James W. Ford		45		Male		White		1957		Bathington	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Heart Disease		Natural		Farmer		High School		Methodist		Married	
Date of Birth		Date of Death		Date of Burial		Place of Burial		Name of Minister		Name of Undertaker	
1912		1957		1957		Bathington		Rev. J. W. Smith		J. W. Smith	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Undertaker		Signature of Deceased		Signature of Family	
J. W. Smith		J. W. Smith		J. W. Smith		J. W. Smith		J. W. Smith		J. W. Smith	

BUREAU V. 2

OCT 31 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 301</u>				d. STREET ADDRESS <u>Rt 301</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laurence Benjamin Ford Jr</u>				4. DATE OF DEATH Month Day Year <u>Oct 18 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 3, 1917</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Laurence Benjamin Ford Jr</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cleopatra Hamilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>7630</u>		17. INFORMANT <u>Mary E. Hamilton, same as #2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tobacco</u> DUE TO <u>7630</u> Conditions, if any, which gave rise to immediate cause (b) <u>Bronchopneumonia</u> (c) <u>Due to</u> cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10-18-57</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u> ADDRESS <u>Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 22 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

2077268XV5

DEPARTMENT OF HEALTH - BATHING 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

NOV 22 1957

RECEIVED

111011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N. C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashville 70X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 114 Ashland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henry Middle Daniel Last Frye			4. DATE OF DEATH Month October Day 6 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/35	9. AGE (in years last birthday) 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ashville, N.C.	
13. FATHER'S NAME Lee W. Frye			14. MOTHER'S MAIDEN NAME Opal Harris		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Gail Rutherford Address Ashville, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the base of the skull (a), stating the underlying cause last. DUE TO (c) Compound comminuted fracture of the left tibia and fibula					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diver of an automobile that was in a collision with another car			
20c. TIME OF INJURY Month, Day, Year Hour 12:58 AM 10/6 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
				20f. (City or town) (County) (State) Capital Heights P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 6, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 10/7/57		22c. NAME OF CEMETERY OR CREMATORY Asheville	
				22d. LOCATION (City, town, or county) (State) North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT-8-57	
				24b. REGISTRAR'S SIGNATURE Overhaugh	

OCT 8 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover x 2 d. STREET ADDRESS 1707 Columbia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruby First Ethel Middle Frye Last 4. DATE OF DEATH Oct. Month 23rd Day 19 Year 57		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 25 Jan. 1890 9. AGE (In years and day) 67 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Tenn. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give no. or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mayola F. Adams (Daughter) Address Same as # 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED October 23, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 27 Oct 1957 22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery 22d. LOCATION (City, town, or county) (State) Henderson Tenn.		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland 24a. REC'D BY REGISTRAR OCT 25 '57 24b. REGISTRAR'S SIGNATURE Rebecca	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH DEPT.

Name of Deceased: John T. Malone, H.D.
 Sex: Male
 Date of Birth: 1907
 Place of Birth: Massachusetts
 Usual Residence: 177 Columbia Ave., Boston, Mass.
 Present Residence: 177 Columbia Ave., Boston, Mass.
 Cause of Death: Unknown
 Date of Death: Oct 25, 1957
 Place of Death: Home
 Signature of Medical Examiner: John T. Malone, H.D.
 Signature of Coroner: John T. Malone, H.D.
 Signature of Registrar: John T. Malone, H.D.

RECEIVED
 OCT 25 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11013

CERTIFICATE OF DEATH

11026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Croome</u>			
c. LENGTH OF STAY IN lb <u>8 min.</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Galloway</u> Middle <u>Baby</u> Last <u>Boy</u>				4. DATE OF DEATH Month <u>22 Oct.</u> Day <u>1957</u> Year <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>22 Oct. 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hagen</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Baskerville</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother</u> Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5- Atelectasis</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>From Birth</u> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 22, 1957</u> to <u>Oct. 22, 1957</u> , that I last saw the deceased alive on <u>Oct. 22, 1957</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamlet St., Hyattsville, Md.</u>			
DATE SIGNED <u>10/23/57</u>							
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>10/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital, Cheverly, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr., Administrator</u>				24a. REC'D BY REGISTRAR <u>W. J. DeLoach</u>		24b. REGISTRAR'S SIGNATURE	

2077379 XVO

CERTIFICATE OF DEATH

11016

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

NOV 1 1957

RECEIVED

1 10984 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

11027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 ETHAN ALLEN AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PATRICK JOSEPH GLEASON First Middle Last				4. DATE OF DEATH OCTOBER 31 Month Day Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRADE FOREMAN, SANITATION DIV., D.C. GOV'T.				10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MARTIN GLEASON				14. MOTHER'S MAIDEN NAME KATHERINE SCOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WM. PAUL GLEASON, 2112 DEXTER AVE., SILVER SPRING Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Failure; Cardiac Asthma. DUE TO (c) arteriosclerotic heart disease 20 years						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) overweight						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1937 , 19____, to 1957 , 19____, that I last saw the deceased alive on 10/30/57 , 19____, and that death occurred at 11:10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2000 P St., N. W., Washington, DC DATE SIGNED 11/2/57							
ACTUAL SIGNATURE Allen E. Lee		M.D. 2000 P St., N. W., Washington, DC					
PHYSICIAN'S NAME (Type) ALLEN E. LEE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF NOV. 5, 1957	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE NOV 6 57		24b. REGISTRAR'S SIGNATURE Paul Smith	

1957
 CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 MARITAL STATUS
 CAUSE OF DEATH
 PLACE OF DEATH
 DATE OF DEATH
 TIME OF DEATH
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR
 OFFICIAL SEAL

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 BUREAU V. I.

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11015

CERTIFICATE OF DEATH

11029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen Hosp</u>		d. STREET ADDRESS <u>3413 R.I. AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Hammett</u> Last <u>Hammett</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>	9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Lucy E. Hammett</u> Address <u>Mt Rainier, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestive edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarction I. V. septum</u> DUE TO (c) <u>Arteriosclerosis of the heart</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/27</u> , 19 <u>57</u> , to <u>10/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/28/57</u> , 19 <u>57</u> , and that death occurred at <u>1 25 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon R. Levitsky</u>		ADDRESS (Street, city or town, state) <u>3408 Rhode Island</u> DATE SIGNED <u>10/28/57</u>	
PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>		<u>Mt Rainier, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>10. SIGNATURE OF WITNESS [REDACTED]</p>		<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF CORONER [REDACTED]</p>	
<p>13. SIGNATURE OF JURY [REDACTED]</p>		<p>14. SIGNATURE OF JUDGE [REDACTED]</p>		<p>15. SIGNATURE OF CLERK [REDACTED]</p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11016

CERTIFICATE OF DEATH

11030

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>2 hr. 15 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>Elaine</u> Last <u>Harrod</u>				4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-19-57</u>	
9. AGE (In years lost birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>George Proctor</u>				14. MOTHER'S MAIDEN NAME <u>Flora Ann Harrod</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Adelle Trower</u> Address <u>Landover, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.4</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>from birth.</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 20, 1957</u> , to <u>Oct 20, 1957</u> , that I last saw the deceased alive on <u>Oct 20, 1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville, Md.</u> DATE SIGNED <u>10/21/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Cash, DE.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernie S. Matthews</u> ADDRESS <u>3619-14th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 28 57</u>		24b. REGISTRAR'S SIGNATURE <u>D. Smith</u>	

2077215xV3

CERTIFICATE OF DEATH

1016

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
FUNDAMENTAL CAUSE		PRE-EXISTING DISEASES	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HISTORICAL DATA	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOCHEMICAL FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. B.

OCT 23 1957

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11017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> <u>x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>Box 1189</u> <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Hawkins</u> Robert First Middle Last <u>Hawkins</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1911</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Prince George Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Bruce Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pinkney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-05-0550</u>		17. INFORMANT (Brother) <u>William Pinkney</u>		Address <u>Campbell Dr Dupont Hgts Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V. A.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-25</u> , 19 <u>57</u> , to <u>10-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-30</u> , 19 <u>57</u> , and that death occurred at <u>9:21 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. A. Fleischer</u> M.D.				ADDRESS (Street, city or town, state) <u>5432 Queens Chapel Rd</u>			
PHYSICIAN'S NAME (Type) <u>RONALD S FLEISCHER</u>				DATE SIGNED <u>11/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov-4-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>4611-Benning Rd. S.E. Wash. DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Spangler</u>				ADDRESS <u>524-8-St N.E. Wash. DC</u>		24b. REC'D BY REGISTRAR <u>W. A. Fleischer</u>	
				24c. DATE <u>NOV 4 57</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12

BUREAU V. S.

NOV 4 1957

RECEIVED

11018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS 6918 6th STREET N.W.			
3. NAME OF DECEASED (Type or print) OLLIE WEBB HOPKINS				4. DATE OF DEATH 10 30 19 57			
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23-1868	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY +		11. BIRTHPLACE (State or foreign country) ILLINOIS	
13. FATHER'S NAME Thomas WEBB				14. MOTHER'S MAIDEN NAME DRUCILLA Riggins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL RECORDS LAUREL SANITARIUM Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TADLESS in mouth 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) repeated cerebral vascular accidents (c) chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction						INTERVAL BETWEEN ONSET AND DEATH 4 days for the past year many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 7 , 19 56 , to Oct. 30 , 19 57 , that I last saw the deceased alive on Oct. 30 , 19 57 , and that death occurred at 6:45 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer				ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 10-30-1957			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				LAUREL MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Chicago Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Sanderson Laurel, Md				24a. REC'D BY REGISTRAR NOV 5 '57		24b. REGISTRAR'S SIGNATURE De Witt Sanderson	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Nov 10 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland	
10. OCCUPATION Teacher		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SURVIVAL OF DEATH None	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None		21. SIGNATURE OF JUDGE None	
22. SIGNATURE OF CLERK None		23. SIGNATURE OF REGISTRAR None		24. SIGNATURE OF NOTARY None	

BUREAU V. S.

NOV 5 1957

RECEIVED

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11033

11019 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u>		STATE <u>Md</u> COUNTY <u>Prince George</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Laurel</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Laurel</u>		CITY OR TOWN <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel General Hospital</u>				STREET ADDRESS <u>435 Main St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Infant Gail Hurley</u>				<u>10-25-57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>		8. DATE OF BIRTH <u>10-24-57</u>	
9. AGE last birthday yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min.			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Laurel, Maryland</u>	
13. FATHER'S NAME <u>Robert C. Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Marsum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT & ADDRESS <u>Robert C. Hurley, Laurel Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
762.0 IMMEDIATE CAUSE (A) <u>Atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Newborn</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Night <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-24</u>, 19<u>57</u>, to <u>10-25</u>, 19<u>57</u>, that I last saw the deceased alive on <u>10/24</u>, 19<u>57</u>, and that death occurred at <u>3 A.</u>M. from the causes and on the date stated above.							
SIGNATURE <u>Samuel P. Weaver Jr.</u>				DATE SIGNED <u>10/26/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>10/26/57</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Randolph, Laurel Md.</u>				26. ADDRESS <u>Laurel Md.</u>			

2083294 XV5

CERTIFICATE OF DEATH

REG. DIST. NO.

1. DEATH OCCURRED ON

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11035

11068

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 N. Forestville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3425 80th Avenue</u>		d. STREET ADDRESS <u>1 3425 80th Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Jacobs</u>		4. DATE OF DEATH Month Day Year <u>Oct. 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16 1880</u>
9. AGE (In years last birthday) yrs. <u>77</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10-12 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>"Clark"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>MR. Joe JACOBS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Hypertensive arteriosclerotic heart disease</u> DUE TO <u>Severe Emphysema + Bronchial</u> DUE TO <u>asthma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>20-25 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Few hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1956</u> to <u>Oct. 15</u> , 1957, that I last saw the deceased alive on <u>10/14/57</u> , 1957, and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney W Lowry</u> M.D.		ADDRESS (Street, city or town, state) <u>1200-d Barebar Pike S.E. Wash 28</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY W LOWRY</u> M.D.		DATE SIGNED <u>Oct 15 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton</u>		24a. REC'D BY REGISTRAR <u>10/16/57</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Carrin Campbell</u>	

CERTIFICATE OF DEATH

11068

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		PERIOD OF ILLNESS <i>2 weeks</i>		PLACE OF DEATH <i>Home</i>	
DATE OF DEATH <i>Oct 15 1957</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		NAME OF NURSE <i>Miss M. Jones</i>		NAME OF ATTENDING CLERGYMAN <i>Rev. W. B. Brown</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF NURSE <i>M. Jones</i>		SIGNATURE OF ATTENDING CLERGYMAN <i>W. B. Brown</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

OCT 18 1957

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 • Item 9 Film G222 11-8-57 et
CERTIFICATE OF DEATH

Reg. Dist. No. **11036**

11020

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg x1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Beatha M. Jefferson				4. DATE OF DEATH Month Day Year Oct 31 1957			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 8 - 1886		9. AGE (In years last birthday) 71 1/2 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bardette Colley				14. MOTHER'S MAIDEN NAME CORA HARRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Robert R. Jefferson 4610 Annapolis Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Attack DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cancer of Lung (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 174X							INTERVAL BETWEEN ONSET AND DEATH Acute
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. p. 12:15 p. m. 1957		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 27 , 1957, to Oct 31 , 1957, that I last saw the deceased alive on Oct 31 , 1957, and that death occurred at 12:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1107 - O Street Wash DC DATE SIGNED Nov 4 57							
ACTUAL SIGNATURE [Signature] M.D. 1107 - O Street Wash DC				DATE SIGNED Nov 4 57			
PHYSICIAN'S NAME (Type) DR. J. FRANCIS DYER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4 57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Shutland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 467 N 3rd Ave				24a. REC'D BY REGISTRAR Nov 4 57		24b. REGISTRAR'S SIGNATURE [Signature]	

05251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11021

CERTIFICATE OF DEATH

11037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 hr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospita</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 Aug. 1957</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Curtis Johnson</u>			
14. MOTHER'S MAIDEN NAME <u>Viola Rateliff</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>viola Johnson 6025 Sheriff Rd. N.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>571.0</u> DUE TO <u>dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> (c) <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>57</u> , to <u>10/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>57</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Tuckin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5301 Hamilton St. 10/20/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-23-57</u>		<u>Lincoln Memorial</u>		<u>Landover, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Rollins</u>				ADDRESS <u>4339 Hunt Pl. N.E.</u>			
24a. REC'D BY REGISTRAR DATE <u>Oct 24 57</u>				24b. REGISTRAR'S SIGNATURE <u>W. Lee</u>			

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BUREAU V. S.

OCT 24 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11069 CERTIFICATE OF DEATH

11038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood 34</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4008-38th St. Apt. A1.</u>				d. STREET ADDRESS <u>4008-38th St. Apt. A1.</u>			
3. NAME OF DECEASED (Type or print) <u>Effie Alice Jones</u> First Middle Last				4. DATE OF DEATH Month <u>10</u> Day <u>17th</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/1/85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR <u>10</u> Months <u>17</u> Days <u>17</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Jacob Coy</u>		14. MOTHER'S MAIDEN NAME <u>Libby Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-18-7783</u>		17. INFORMANT <u>Kinsey Jones - Westport, Conn.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 1, 1954</u> to <u>Oct. 17, 1957</u> , that I last saw the deceased alive on <u>Oct. 17, 1957</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl W. Graff</u> M.D. <u>2716 Kirkwood Place</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>EARL W. GRAFF, MD.</u> <u>W. Hyattsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> ADDRESS <u>Mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 23 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

1957

BUREAU V. S.

OCT 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11039**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN 1b Day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47A-3 d. STREET ADDRESS 1123 West Virginia Ave N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle Aline Last Jones		4. DATE OF DEATH Month October Day 31 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1927
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Jones		14. MOTHER'S MAIDEN NAME Melissa Whitfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. M. Jones		Address 1123 West Va. Ave., N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous rupture of cerebral artery DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Washington, D.C.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED October 31, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-5-57 Lincoln	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Tracy's Funeral Home		24a. REC'D BY REGISTRAR NOV 4 '57	24b. REGISTRAR'S SIGNATURE W. H. ...

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

City of Boston

Residence

Age

Sex

Business of the decedent

James

Alma

Swedish

May 12, 1957

Colored

Female

Washington, D.C.

U.S. Govt

Black

Florida, U.S.

George Jones

U.S. Govt

Residence of decedent

Professional occupation

Domestic worker of colored race

Signature of physician

BUREAU V. S.

NOV 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11040

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Central Avenue		d. STREET ADDRESS Central Avenue	
3. NAME OF DECEASED (Type or print) First Francis Middle Warren Last Jones		4. DATE OF DEATH Month October Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1957
9. AGE (In years last birthday) yrs. 4 Months 15 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Earl B. Jones		14. MOTHER'S MAIDEN NAME Frances Ruth Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Frances Jones , Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) Toxemia (a), stating the underlying cause last. (c) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED October 16, 1957	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Oct. 18/57		22b. DATE THEREOF Oct. 18/57	
22c. NAME OF CEMETERY OR CREMATORY Not listed		22d. LOCATION (City, town, or county) (State) Mitchellville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ad. Solomon		24a. REC'D BY REGISTRAR OCT 22 1957	
24b. REGISTRAR'S SIGNATURE Agnes Youngling			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
John J. Williams	October 22, 1957	Home	Coronary artery disease
SEX	AGE	EDUCATION	OCCUPATION
Male	65	High School	None
DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH
June 1, 1892	October 22, 1957	U. S. A.	U. S. A.
DATE OF DEATH	DATE OF DEATH	DATE OF DEATH	DATE OF DEATH
October 22, 1957	October 22, 1957	October 22, 1957	October 22, 1957

BUREAU V. 3

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11022

CERTIFICATE OF DEATH

Reg. Dist. No.

11041

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C. 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		d. STREET ADDRESS <u>627 PENN. AVE S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>OTILIA</u> Middle <u>M.</u> Last <u>KEMPERLY</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNING STORE 22</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN JOSEPHANN</u>		14. MOTHER'S MAIDEN NAME <u>OTILIA WALTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-46-6515</u>	
17. INFORMANT <u>Hospital RECORDS LAUREL SANITARIUM</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Drainsyndrome associated with</u> (c) <u>Cerebral arteriosclerosis with psychotic reaction</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>reaction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 many years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7 - 1956</u> , to <u>Oct. 2 - 1957</u> , that I last saw the deceased alive on <u>October 2 - 1957</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Linda P. Kraemer</u>		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER LAUREL</u>		DATE SIGNED <u>Oct. 2-1957</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 5, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>		24a. REC'D BY REGISTRAR <u>OCT 4 '57</u>	
ADDRESS <u>317 Pa. Ave., SE DC3</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

— — —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11023

CERTIFICATE OF DEATH

11042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Berwyn Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hospital		d. STREET ADDRESS 6201 Semiole St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Julia M Kidd		4. DATE OF DEATH Month Day Year Oct. 12 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1890
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Ozmar		14. MOTHER'S MAIDEN NAME Kate Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----	
17. INFORMANT Mrs Grace Humphreys		Address Berwyn Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to Oct. 12, 1957, that I last saw the deceased alive on Oct. 12, 1957, and that death occurred at 11/30 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Leon R. Levitsky M.D.		3408 Rhode Island St. Kensington 2d 10/12/57	
PHYSICIAN'S NAME (Type) Leon R. Levitsky			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 10/13/57		22b. DATE THEREOF 10/13/57	
22c. NAME OF CEMETERY OR CREMATORY Petersburg		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE OCT 15 57		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

PART OF STATE COUNTY OF BALTIMORE CITY OF BALTIMORE		DECEASED NAME JAMES GEORGE	
DATE OF DEATH JULY 1, 1957		PLACE OF DEATH HOME	
TIME OF DEATH 10:00 A.M.		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH JULY 1, 1900	
SEX MALE		RACE WHITE	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
EDUCATION GRADE 8		RELIGION METHODIST	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. S.

OCT 15 1957

RECEIVED

11024

CERTIFICATE OF DEATH

11043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b admr. April 26-57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS 2675 Rhode Island Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ABBE I. KINDER				4. DATE OF DEATH Month October Day 8 Year 1957			
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-6-1879	9. AGE (In years lost birthday) yrs. 79	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES CASSINS CRAY				14. MOTHER'S MAIDEN NAME JOSEPHINE ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORDS, LAUREL SANITARIUM			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) many years DUE TO (c) many years						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic Brain syndrome associated with cerebral arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June-7 , 19 56 , to OCT-8 , 19 57 , that I last saw the deceased alive on OCT-8 , 19 57 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE ERIKA P. KRAEMER		M.D. LAUREL SANITARIUM		ADDRESS (Street, city or town, state) LAUREL SANITARIUM		DATE SIGNED 10-8-57	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-57		22c. NAME OF CEMETERY OR CREMATORY Fork Lincoln		22d. LOCATION (City, town, or county) (State) Bladenburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home				ADDRESS 4812 Hager Rd		24a. REC'D BY REGISTRAR DATE OCT 14 '57	
				24b. REGISTRAR'S SIGNATURE Redman			

CERTIFICATE OF DEATH

1102A

BUREAU V. B

OCT 14 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Have spoken with and cleared with Dr. Maloney, coroner

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 1, Film G222 10/31/57 rev									
11025 CERTIFICATE OF DEATH									
Reg. Dist. No. 11044 245									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE SAME b. COUNTY P. G.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly BRENTWOOD			c. LENGTH OF STAY IN 1b 4 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE HOSP. DOA					d. STREET ADDRESS 14004-38th. Brentwood Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEON Middle KLAPPHOLTZ Last KLAPPHOLTZ					4. DATE OF DEATH Month Oct. Day 23 Year 1957				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 9, 1910		9. AGE (In years last birthday) yrs. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY WORKER		10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) N. JERSEY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME HARRY					14. MOTHER'S MAIDEN NAME ANN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT WIFE			Address SAME		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROB. CEREBRAL EMBOLUS 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HT. DISEASE DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH MINUTES NOT KNOWN 6-10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 to 10-23 , 1957, that I last saw the deceased alive on 10-9 , 1957, and that death occurred at 8 p. M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Jack J. Rheingold				ADDRESS (Street, city or town, state) 1302 18th St. h.w. Wood			DATE SIGNED 10/23/57 DC		
PHYSICIAN'S NAME (Type) JACK J. RHEINGOLD									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY HEBREW CEMETERY			22d. LOCATION (City, town, or county) (State) NEWARK N. J.		
23. FUNERAL DIRECTOR'S SIGNATURE B. D. Dargatzis				ADDRESS 3501-14th St. N.W.		24a. REC'D BY REGISTRAR DATE Oct. 25, 1957		24b. REGISTRAR'S SIGNATURE Mrs. Jas. S. Senechal <i>Deputy</i>	

CERTIFICATE OF DEATH

11-1-58

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BUREAU V. 3

OCT 28 1957

RECEIVED

11-1-58

JACK E. KHEIN 300

CERTIFICATE OF DEATH

11045

Reg. Dist. No.

11026

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN TB <u>1 month 4 1/2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>14706 Sheridan St.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Lydia Eleanor Klaus</u>				4. DATE OF DEATH Month Day Year <u>October 24 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1883 10-14-1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otto August Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Eleanora Schlicht</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>general debility</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis to liver & pancreas</u> 4 mo DUE TO (c) <u>Carcinoma of stomach</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-8</u> , 19 <u>57</u> , to <u>10-24</u> , 19 <u>57</u> that I last saw the deceased alive on <u>10-23</u> , 19 <u>57</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>14404 QUEENS BURY Rd Riverdale Ind</u> DATE SIGNED <u>10/24/57</u>							
ACTUAL SIGNATURE <u>R. F. Wilkinson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>R. F. WILKINSON MD</u>							
22a. BURIAL, CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/24/57</u>		<u>Baltimore</u>		<u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Henry Sons</u> ADDRESS <u>2024 Orleans St</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Sweeney</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11000

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1912</i></p>	
<p>5. PLACE OF BIRTH <i>New York</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>		<p>8. DATE OF DEATH <i>Nov 5 1957</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>11. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>14. SIGNATURE OF CORONER <i>John Doe</i></p>	

BUREAU V. S.

NOV 5 1957

RECEIVED

11027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 ROGERS HIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION <u>PRINCE GEORGE HOSPITAL</u>				d. STREET ADDRESS <u>15308 HAMILTON ST</u>			
3. NAME OF DECEASED (Type or print) First <u>WADE</u> Middle <u>Koontz</u> Last <u>Koontz</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Navy yard</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
13. FATHER'S NAME <u>Jacob F. Koontz</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kialing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Brooklyn Koontz - 5308 Hamilton St - Rogers Hight Rd -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Brain Sclerosis, Heart Disease 10 years.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-19-1957</u> , to <u>10-20-1957</u> , that I last saw the deceased alive on <u>10-19-1957</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert H. Hottel</u> M.D.				ADDRESS (Street, city or town, state) <u>Reverend, Md 11-21-57</u>			
DATE SIGNED <u>11-21-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>OCT. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Columbia Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u> ADDRESS <u>Wash. D. C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	
				DATE <u>OCT 22 57</u>			

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

DECEASED

BUREAU V. R.

OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 47X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3500 13th St N. W.	
3. NAME OF DECEASED (Type or print) Gladys Elizabeth Lancaster		4. DATE OF DEATH Month October Day 26, Year 19 57.	
5. SEX female		6. COLOR OR RACE colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 10, 1914	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Piscataway, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jarriett T. Lancaster		14. MOTHER'S MAIDEN NAME Irene J. Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mabel L. Johnson		Address Brandywine, Md Route 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed skull (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant Jan auto that was in a collision	
20c. TIME OF INJURY Month, Day, Year 2:30 a.m. 10-26-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Arlon Hill Pg. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Oct 26, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.31.57	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cat. Ch. Cemetery		22d. LOCATION (City, town, or county) (State) Piscataway, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Oct 30 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11029

CERTIFICATE OF DEATH

11048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Marshall Last LaRue		4. DATE OF DEATH Month Oct. Day 28 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Nov 1881
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Weeping Water, Nebr.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Marshall		14. MOTHER'S MAIDEN NAME Medella Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT George R. LaRue		Address 7203 Wells Parkway Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma (c) Carcinoma of breast		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to Oct. 28th , 19 57 , that I last saw the deceased alive on Oct. 28th , 19 57 , and that death occurred at 1:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon L. Gallin		ADDRESS (Street, city or town, state) DATE SIGNED 10/28/1957	
PHYSICIAN'S NAME (Type) Dr. Leon L. Gallin		M.D. 7206 Colesville Road, Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1/1957	
22c. NAME OF CEMETERY OR CREMATORY George Washington Cem		22d. LOCATION (City, town, or county) (State) Riggs Rd. Extd. Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 5801 Cleveland Ave. Riverdale Md.	
24a. REC'D BY REGISTRAR NOV 1 '57		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11049

Reg. Dist. No.

FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 14 College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 4905 Erie Street	
3. NAME OF DECEASED (Type or print) Zeral Osborne Law		4. DATE OF DEATH Oct. 5, 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.C. Fireman	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George Pinkney Law		14. MOTHER'S MAIDEN NAME Sarah Francis McDowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.1		16. SOCIAL SECURITY NO.	
17. INFORMANT John L. Law; 5102 Mineola Rd. College Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED Oct. 5, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/8/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOONG COMPANY 1300- N. STREET N.W. 8 1957		24a. REC'D BY REGISTRAR James Sever	
24b. REGISTRAR'S SIGNATURE		25. ADDRESS WASHINGTON, 5, D.C.	

1957 8 OCT

RECEIVED

11031

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 8 hrs 25 Min x 2 SEAT PLEASANT,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Mary Last LAURENZI		4. DATE OF DEATH Month Oct Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1884 73 yrs.
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None H-wife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None H-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Happy W. Geety		14. MOTHER'S MAIDEN NAME EMMA (UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-14-3826	
17. INFORMANT Harvey C. Laurenzi (Son)		Address 7022 Central Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral atherosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 19, 1957 to Oct 19, 1957 , that I last saw the deceased alive on Oct. 19, 1957 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Duus		ADDRESS (Street, city or town, state) DATE SIGNED 6124 Central Ave. Cap. Hgts Md.	
PHYSICIAN'S NAME (Type) DR. PETER DUUS			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10/24/57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.	22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 577-11th St SE Wash, DC	24a. REC'D BY REGISTRAR Oct 22 57
		24b. REGISTRAR'S SIGNATURE Deedman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

CT 22 1957

RECEIVED

11032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital				d. STREET ADDRESS 14 L Laurel Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Stanley Lawrence				4. DATE OF DEATH Month October 14, 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/57	9. AGE (In years last birthday) yrs. 21	IF UNDER 1 YEAR Months 21	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Lawrence				14. MOTHER'S MAIDEN NAME Margaret Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Obstruction</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 d 2 d
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Strangulated Rb. Inguinal Hernia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Sept 23, 1957, to Oct 14, 1957, that I last saw the deceased alive on Oct 13, 1957, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William Eisner		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 30 B Ridge Rd Greenbelt Md 10/14/57					
PHYSICIAN'S NAME (Type) William Eisner		Greenbelt, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/15/57	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE OCT 17 57		24b. REGISTRAR'S SIGNATURE O'Brien		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11072

CERTIFICATE OF DEATH

11052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST Hgths</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST Hgths x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3814-23rd Pl.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES M. LAZZARI</u>				4. DATE OF DEATH <u>OCTOBER 4 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 6 1890</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED COOK.</u>		11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAURENCE LAZZARI</u>				14. MOTHER'S MAIDEN NAME <u>MARIEA F. FERRO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>TINO LAZZARI</u> Address <u>5814 23rd PL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the liver</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 20, 1957</u> , to <u>October 4, 1957</u> , that I last saw the deceased alive on <u>October 3, 1957</u> , and that death occurred at <u>U. S. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. Etienne Szollosi</u> M.D.				ADDRESS (Street, city or town, state) <u>2 Parkway 2 Forest Hgts</u> DATE SIGNED <u>10/4/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Etienne Szollosi</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr.</u> ADDRESS <u>517-11th St. N.E.</u>				24a. REC'D BY REGISTRAR <u>OCT 7 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be returned to the funeral director, who will be retained by the hospital or attending physician. Page 5
page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7
the release prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11053

11033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b 3 days 23 hours x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1 6402 L Street	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Lee		4. DATE OF DEATH Month 10 Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-57
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lee		14. MOTHER'S MAIDEN NAME Dorothy Gaylord	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT mother		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death from birth from birth			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/19/57 , to 10/23/57 , that I last saw the deceased alive on 10/23/57 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE John W. Perkins M.D. 5301 Hamilton St., Hyattsville, Md. DATE SIGNED 10/25/57 PHYSICIAN'S NAME (Type) John W. Perkins			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Smithland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517-11th St. S. E.		24a. REC'D BY REGISTRAR OCT 29 '57	
24b. REGISTRAR'S SIGNATURE Dee			

2007-02-02 02:16

Figure 12-1

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2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

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BUREAU V. S.

OCT 29 1957

RECEIVED

11034

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 17			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle LEONARD Last LEONARD				4. DATE OF DEATH Month OCTOBER Day 1 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-57	
9. AGE (In years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Henry Leonard		14. MOTHER'S MAIDEN NAME Zilla Ann BISH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Zilla Ann BISH Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurely DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/30 , 19 57 , to 10/1 , 19 57 , that I last saw the deceased alive on 10/1 , 19 57 , and that death occurred at 11/30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin		M.D. 6124 Central Ave		DATE SIGNED 10/4/57			
PHYSICIAN'S NAME (Type) WM BRAININ		ADDRESS Capitol Hts Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/15/57		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn				24a. REC'D BY REGISTRAR OCT 18 57		24b. REGISTRAR'S SIGNATURE Paul	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077221XV3

CERTIFICATE OF DEATH

DECEASED'S NAME		LAST NAME		FIRST NAME		MIDDLE NAME	
TAYLOR, JANE		TAYLOR		JANE			
DATE OF BIRTH		PLACE OF BIRTH		RACE		SEX	
OCTOBER 1, 1927		BALTIMORE, MARYLAND		WHITE		FEMALE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
OCTOBER 1, 1957		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION		REGISTRAR'S NAME		REGISTRAR'S TITLE	
OCTOBER 1, 1957		BALTIMORE, MARYLAND		J. H. SMITH		REGISTRAR	

BUREAU V. S.

OCT 18 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10985 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 40 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 807 Davis Avenue			d. STREET ADDRESS 807 Davis Avenue		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harry (nmi) Middle Loveday Last			4. DATE OF DEATH Month October Day 2nd , Year 19 57		
5. SEX M le	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-90		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Loveday			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW#1 578-32-4496	17. INFORMANT Arnold Loveday; 2109 Brighton Rd. Avondale, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary thrombosis (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. M. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. M. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-2-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF DEATH Oct. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumpkey,		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 4 1957	
				24b. REGISTRAR'S SIGNATURE U. W. Schuch	

BUREAU V. S.

Figure 6

110562/j

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 30 1957

RECEIVED

1

11035

11057

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4804 -52nd. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Alma Last Mahone				4. DATE OF DEATH Month OCTOBER Day 13 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20th, 1902	
9. AGE (In years last birthday) 55 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William Thomas Gallagher			
14. MOTHER'S MAIDEN NAME Dora Frances Bowles				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Walter E. Mahone, 4804--52nd Ave. Edmonston Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & subdiag. absc. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Refrigerator DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. n. Month 19 Day 19 Year 1957 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 10-13				20g. (County) 57		20h. (State) 1957	
21. I certify that I attended the deceased from 10-13-57 , 19 10-13 , that I last saw the deceased alive on 10-13-57 , 19 10-13 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dayton Watkins M.D.				ADDRESS (Street, city or town, state) 5304 Annapolis Rd 10-13-57			
PHYSICIAN'S NAME (Type) DAYTON WATKINS				Bladensburg Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chamber				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE OCT 16 '57	
24b. REGISTRAR'S SIGNATURE Quelch							

CERTIFICATE OF DEATH

See this for

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		Baltimore		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
1957		10:00 AM		Home		Baltimore		Heart Disease		Natural		Teacher		[Signature]		[Signature]		1957		10:00 AM	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
1957		10:00 AM		Home		Baltimore		Heart Disease		Natural		Teacher		[Signature]		[Signature]		1957		10:00 AM	

BUREAU V. S.

OCT 16 1957

RECEIVED

11036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>Dead on arrival</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights x2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>				d. STREET ADDRESS <u>5908 21st Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Michele</u> Last <u>Marasciula</u>				4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 19, 1925</u>	9. AGE (In years last birthday) <u>31</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lawrence T. Vallario</u>				14. MOTHER'S MAIDEN NAME <u>Antionette Pappa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Nicholas J. Marasciula, same as # 2</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>9731</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Carbon Monoxide Poisoning</u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran motor of car while she was closed in garage</u>					
20c. TIME OF INJURY Month, Day, Year <u>10/13/57</u> Hour <u>3:00</u> a.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garage at home</u>		20f. (City or town) (County) (State) <u>Hillcrest Heights P. G. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DATE SIGNED <u>October 13, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Penna. Ave., SE Washington 3, D.C.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>Oct 15 57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

OCT 15 1957

RECEIVED

11074

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO CHILLUM</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5808-10th PL.</u>	
3. NAME OF DECEASED (Type or print) <u>Alexander</u> First <u>Mates</u> Middle <u>Mates</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-8-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MGR. RETAIL LIQUOR STORE</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
13. FATHER'S NAME <u>HENRY-</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-46-3399</u>	
17. INFORMANT <u>BERNARD MATES</u>		Address <u>Hyattsville Md. 706-CROSBY RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C. V. D. - Severe.</u> (c) <u>10 YRS</u> <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 1950</u> to <u>10-24, 1957</u> , that I last saw the deceased alive on <u>10/22, 1957</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>915 19th St. NW</u>		DATE SIGNED <u>10/24/57</u>	
ACTUAL SIGNATURE <u>William Kurstin MD</u>		PHYSICIAN'S NAME (Type) <u>William Kurstin MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL Cem</u>		22d. LOCATION (City, town, or county) (State) <u>OXON HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grubbs Funeral Home</u>		ADDRESS <u>4217-9th St NW</u>	
24a. REC'D BY REGISTRAR <u>James</u>		24b. REGISTRAR'S SIGNATURE <u>James</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-10-57

PLACE OF DEATH		HOSPITAL		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. COLOR	
7. PLACE OF BIRTH		8. DATE OF BIRTH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

BUREAU V. S.

OCT 25 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Matthews		4. DATE OF DEATH Month Oct. Day 1, Year 19 57	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McKinley Matthews		14. MOTHER'S MAIDEN NAME Gertrude Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.2		17. INFORMANT Address William Matthews; same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of abdomen DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by a police officer in the performance of his duty.	
20c. TIME OF INJURY Month, Day, Year 8.13 p.m. Oct. 2, 1957	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Laurel. (County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED October 1, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT 4/57	22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL BALTO	22d. LOCATION (City, town, or county) (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby		24a. REG. BY REGISTRAR Oct 7 1957 24b. REGISTRAR'S SIGNATURE Ridgley Selby	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11061

Items 3,6 Film 222 10-29-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1103 Lancaster Road		d. STREET ADDRESS 1103 Lancaster Road	
3. NAME OF DECEASED (Type or print) First Katherine Middle Lee Last Mooyer (Catherine Mooyer)		4. DATE OF DEATH Month October Day 20 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-65
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Summerlot		14. MOTHER'S MAIDEN NAME Unknown Margaret Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George Spillman; same address.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease. 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Senility			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Moloney		DATE SIGNED October 21, 1957	
EXAMINER'S NAME (Type) John T. Moloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR 3000 E. Balto. St. Balto.	
24b. REGISTRAR'S SIGNATURE Oct 23 57			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND ST. DEPT. OF HEALTH - BALTIMORE 12
100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Place of Birth		Date of Birth	
Place of Death		Date of Death	
Cause of Death		Manner of Death	
Medical History		Social History	
Physical Examination		Mental Examination	
Laboratory Examinations		X-ray Examinations	
Pathological Findings		Microscopic Findings	
Toxicology		Other Findings	

BUREAU V. S.

OCT-23-1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Silver Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4500 Block St. Barnabas Road				d. STREET ADDRESS 1 5101 St. Barnabas Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Alvin Last Moreland				4. DATE OF DEATH Month Oct. Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1935	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wilson Moreland				14. MOTHER'S MAIDEN NAME Daisey Varnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Earl W. Moreland, 4340 St. Barnabas Road S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound fracture of th skull, crushed, abdomen and pelvis cause last, stating the underlying (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple abrasions and contusion							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off road and struck a pole					
20c. TIME OF INJURY Month, Day, Year 1:00 a.m. 10/ 8 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Silver Hill P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED 10/8/57			
EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10-57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				24. REC'D BY REGISTRAR 1661 Good Hope Road SE Washington 20, D.C.		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

11070101 EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11076

CERTIFICATE OF DEATH

11063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.		d. STREET ADDRESS 1609 VARNUM ST. N.W.	
3. NAME OF DECEASED (Type or print) First NICK Middle (NONE) Last NEAM		4. DATE OF DEATH Month 10 Day 16 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1899
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY DELICATESSEN	
11. BIRTHPLACE (State or foreign country) SYRIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JACOB NEAM		14. MOTHER'S MAIDEN NAME CARRIE DAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DECEASED		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 5 DAYS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOGENIC CARCINOMA RT. LUNG; RIGHT LOWER LOBECTOMY 10/16/57			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/11 , 19 57 , to 10/16 , 19 57 , that I last saw the deceased alive on 10/16 , 19 57 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) GLENN DALE HOSP. DATE SIGNED 10/16/57 ACTUAL SIGNATURE MOE WEISS M.D. GLENN DALE, M.D. PHYSICIAN'S NAME (Type) MOE WEISS MD. GLENN DALE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-19-57	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Harris		24a. REC'D BY REGISTRAR 10/18/57	
ADDRESS 2901-14th St. N.W. Wash, D.C.		24b. REGISTRAR'S SIGNATURE Glenn Dale	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1-5028

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		12-1-28		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
SALES		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
OCT 18 1957
BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12262

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 5215 Rainier Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			
3. NAME OF DECEASED (Type or print) Francis Newyahr		4. DATE OF DEATH October 13 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-19
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gasoline service	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Joseph Newyahr		14. MOTHER'S MAIDEN NAME Virginia Weaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.2		16. SOCIAL SECURITY NO. Eleanor Govitch, Laurel, Md.	
17. INFORMANT Address Eleanor Govitch, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (b) 331x (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 17, 1957	
22c. NAME OF CEMETERY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR 18 '57 24b. REGISTRAR'S SIGNATURE Alfred	

STATE OF
DEATH

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *George Washington*
AGE: *45* SEX: *Male*
RACE: *White* BIRTH DATE: *1-1-1900*
RESIDENCE: *2215 1st Avenue*
OCCUPATION: *Electrician*
CAUSE OF DEATH: *Coronary vascular accident*
MANNER OF DEATH: *Natural*
PLACE OF DEATH: *Home*
DATE OF DEATH: *Oct 18, 1957*
SIGNATURE OF EXAMINER: *James H. [illegible]*
DATE OF SIGNATURE: *Oct 18, 1957*

RECEIVED
OCT 18 1957
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11039

CERTIFICATE OF DEATH

Reg. Dist. No.

11064

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 E. Columbia Park,</u>			
c. LENGTH OF STAY IN 1b <u>19H 35M</u>				d. STREET ADDRESS <u>7719 Ridge Dr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>F</u> Last <u>Norton</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-70</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes</u>			
17. INFORMANT <u>Mrs. Zelphia H. Raum</u> Address <u>7719 Ridge Dr. Landover, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute sub. edema & arterio sclerosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart failure</u> DUE TO (c) <u>Arterio sclerosis of the heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/26</u> , 19 <u>57</u> , to <u>10/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/27</u> , 19 <u>57</u> , and that death occurred at <u>2:25P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. John Kehoe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 31, 1957</u>		<u>Cedar Hill Cemetery</u>		<u>Southland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>VV W Chambers</u> ADDRESS <u>510 11th St SE</u>				24a. REC'D BY REGISTRAR <u>DATE 31 '57</u> 24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11065

11040

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution:—Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ollie Middle B. Last Pace		4. DATE OF DEATH Month Oct. Day 9 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 3 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harney Koon		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 6206 Field St	
17. INFORMANT Murray Pace		Address 6206 Field St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure c Acute Pulmonary 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) Edema		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? Multiple Myeloma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1- , 19 57 , to 10-9- , 19 57 , that I last saw the deceased alive on 10-9- , 19 57 , and that death occurred at 1:18 p. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold A. Lear		DATE SIGNED 10-10-57	
PHYSICIAN'S NAME (Type) ARNOLD A. LEAR		ADDRESS (Street, city or town, state) 905 Shoreland St Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 517 11th St S.E.	
24a. REC'D BY REGISTRAR Oct 14 1957		24b. REGISTRAR'S SIGNATURE Donna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11068

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11041

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 5602 16th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			
3. NAME OF DECEASED (Type or print) John Anthony Phillips		4. DATE OF DEATH Month October Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-18
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Anthony Phillips		14. MOTHER'S MAIDEN NAME Dora McMurtry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dimple Phillips;		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fractured skull (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Received during an altercation.	
20c. TIME OF INJURY Month, Day, Year Hour 7.00 p. m. 10-16 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Food store		20f. (City or town) (County) (State) Mt. Rainier, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 17, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 19, 1957	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE OCT 21 '57			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 21 1957

BUREAU V. 2

Received during an altercation.

Fractured skull

Intercranial hemorrhage

Skull fracture

Anthony Williams

John Williams

Left chest

Grocery

Antennas

John Anthony Williams

October

1957

John

Williams

Cherry

It has been

England

U.S.A.

11077

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSPITAL				d. STREET ADDRESS 725 QUEBEC PL. N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First OLIVIA Middle P. Last POWELL				4. DATE OF DEATH Month OCT. Day 5 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/10	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK TYPIST				10b. KIND OF BUSINESS OR INDUSTRY FOREIGN CLAIM SETTLM.		11. BIRTHPLACE (State or foreign country) MISSISSIPPI	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME DAN POSEY				14. MOTHER'S MAIDEN NAME BESSIE DUCKSWORTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 577-52-3143		17. INFORMANT DECEASED	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 7 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ (County) _____ (State)	
21. I certify that I attended the deceased from 7/18/56 , 19____, to 10/5 , 19____, that I last saw the deceased alive on 10/4 , 19____, and that death occurred at 4:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Moie Weiss M.D. M.D. GLENN DALE HOSPITAL 10/5/57 PHYSICIAN'S NAME (Type) MOE WEISS M.D. GLENN DALE, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/6/57		22c. NAME OF CEMETERY OR CREMATORY _____		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Shuman + Shuman 1702 1st St				24a. REC'D BY REGISTRAR DATE OCT 8 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11068

Reg. Dist. No.

11078

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gregory Estates</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gregory Estates x2</u>		d. STREET ADDRESS <u>7010 Greig Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7010 Greig Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Howard Rayley</u>				4. DATE OF DEATH Month Day Year <u>Oct 22 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17, 1915</u>	9. AGE (In years last birthday) <u>42 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>George R Rayley</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>Florence M. Stiene, Capital Hts, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gun shot wound of abdomen</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (p)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in abdomen with shot gun</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>10-22-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Gregory Estates P.S. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 517-11th St. S.E.</u>				24a. REC'D BY REGISTRAR <u>Oct 22 '57</u>			
				24b. REGISTRAR'S SIGNATURE <u>Oct 22 '57</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11042

CERTIFICATE OF DEATH

Reg. Dist. No.

11069

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>10 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Heights Estates</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>3900 CALVERTON DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM Xenophen Reid</u>				4. DATE OF DEATH Month Day Year <u>Oct 5 1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 28, 1871</u>		
9. AGE (In years, last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Banker</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown - daughter</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give for or dates of service)</u>		17. INFORMANT <u>MRS E.S. EARNHART</u> Address <u>3900 CALVERTON DR.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>OCT 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT 5</u> , 19 <u>57</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Norman Donati Comeau</u>				ADDRESS (Street, city or town, state) <u>3503 Penny St</u>		DATE SIGNED <u>10/5/57</u>		
PHYSICIAN'S NAME (Type) <u>NORMAN DONATI COMEAU</u>				M.D. <u>MT RAINIER MD.</u>				
22a. BURIAL, CREMATION, REMOVAL (Type)		22b. DATE THEREOF <u>Oct 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hickory</u>		22d. LOCATION (City, town, or county) (State) <u>North Carolina</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Oct 8 '57</u>		
				24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>				

2504

BUREAU V.

OCT 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10978

11079

Items 8 & 9, Film G-222 11/19/57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 HYATTSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3929 NICHOLSON ST (Home)				d. STREET ADDRESS 13929 NICHOLSON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CAROLYN Middle MILLER Last RICHARDS				4. DATE OF DEATH Month OCT. Day 20 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 6, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY New Hope, Ky.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk -			14. MOTHER'S MAIDEN NAME Ellice Humphrey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none none		16. SOCIAL SECURITY NO. none		17. INFORMANT MRS HARRISON HUGHES Address Hyattsville Ind - 4101 Ogden Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1-2 days 2+ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 1956, to OCT. 19 , 1957, that I last saw the deceased alive on OCT. 19 , 1957, and that death occurred at 4 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 Sheridan St. Hyattsville Maryland DATE SIGNED 10-20-57							
ACTUAL SIGNATURE Arnold A Lear		M.D. 905 Sheridan St. Hyattsville Maryland					
PHYSICIAN'S NAME (Type) ARNOLD A LEAR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Cone Hill Cemetery		22d. LOCATION (City, town, or county) (State) Louisville, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lees Sons Co. Washington DC				24. REGISTRAR'S SIGNATURE J. Wm Lees Sons Co. Washington DC		24b. REGISTRAR'S SIGNATURE J. Wm Lees Sons Co. Washington DC	

CERTIFICATE OF DEATH

1957

BUREAU V. S.

OCT 22 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chapel Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8921- Cold Fort Road		d. STREET ADDRESS 18921 Cold Fort Rd	
3. NAME OF DECEASED (Type or print) First Middle Last Walter R Richardson		4. DATE OF DEATH Month Day Year Oct 5 1957	
5. SEX male	6. COLOR OR RACE Celanoid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johnson		14. MOTHER'S MAIDEN NAME Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clarence C. Chant		Address 8921 Cold Fort Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion (b) Cardiac vascular renal disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED Oct 5, 1957	
EXAMINER'S NAME (Type) JAMES I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 18 Oct 57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Wash., D.C.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines Co.		24a. REC'D BY REGISTRAR OCT 8 57	
ADDRESS 901 3St., N.W. Wash., D.C.		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 8 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11043

CERTIFICATE OF DEATH

Reg. Dist. No.

11072

1. PLACE OF DEATH COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 4801 M. Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Rupert Last Rupert				4. DATE OF DEATH Month Oct. Day 26 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1882	
9. AGE (In years, months, and days) 75 yrs.		IF UNDER 1 YEAR Months 10 Days 26 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Geese Creek, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Stein				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Charles S Rupert				Address Hillside Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic malnutrition DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hillside				20g. (County) Prince George		20h. (State) Md.	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. H. Lear				DATE SIGNED 10-26-57			
PHYSICIAN'S NAME (Type) Dr. H. Lear				ADDRESS (Street, city or town, state) Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Hall		22d. LOCATION (City, town, or county) (State) 71 Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 517-11 St. SE.		24a. REC'D BY REGISTRAR Oct 30 57	
24b. REGISTRAR'S SIGNATURE W.W. Chambers							

BUREAU V.

30 OCT 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11080

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11073 34

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville	c. LENGTH OF STAY IN 1b 2 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7621 Walter's Lane		e. STREET ADDRESS 7621 Walters Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Susan Elizabeth Sackett	4. DATE OF DEATH October 23 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 69 yrs.
9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Personal papers		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED October 24, 1957	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <input checked="" type="checkbox"/>	22b. DATE THEREOF 10-24-57	22c. NAME OF CEMETERY OR CREMATORY V. of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE 28 1957	
		24b. REGISTRAR'S SIGNATURE Rene Campbell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 28 1957

BUREAU V. 2

Central reports

Organizational chart

Organizational chart

Clark

Perlin

Wills

Grant

Edgerton

Robert

October 23

Wolfe

Wolfe

Wolfe

Wolfe

Wolfe

Wolfe

FOR STATE
HEALTH DEPT

10979

CERTIFICATE OF DEATH

11075 n/s
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8, 030.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5801-42nd Ave.				d. STREET ADDRESS Old Court Road			
3. NAME OF DECEASED (Type or print) Emma M. Schildwachter First Middle Last				4. DATE OF DEATH Birth 12-17-1923			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH death 10/8/57	
9. AGE (In years last birthday) 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carl T. Johnson Jr.				14. MOTHER'S MAIDEN NAME Ethel L. McIntosh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. 216-16-0056		17. INFORMANT Stephen L. Schildwachter Address Pikesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Ca of Ovary 2 yrs (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-18-57, 1957 to 10-8-57, 1957 that I last saw the deceased alive on 10-8-57, 1957, and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. Clum M.D.				DATE SIGNED 10-9-57			
PHYSICIAN'S NAME (Type) John P. Clum							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/57		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Riggs Rd. Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mt. Rainier Md. Valley's Funeral Home Inc.				24a. REC'D BY REGISTRAR DATE 11 1957		24b. REGISTRAR'S SIGNATURE James E. Gougeon	

CERTIFICATE OF DEATH

10873

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1912	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. ST. BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
OCT 11 1957		HOME		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
OCT 11 1957		OCT 11 1957		OCT 11 1957		OCT 11 1957	

BUREAU V. S.

OCT 11 1957

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11044
CERTIFICATE OF DEATH

11076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. Hosp</u>		d. STREET ADDRESS <u>6109-39th Pl.</u>	
3. NAME OF DECEASED (Type or print) First <u>DORCAS</u> Middle <u>C</u> Last <u>SCRUGGS</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-01</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fun Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Coy</u>		14. MOTHER'S MAIDEN NAME <u>Martha ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James M. Scruggs</u>		Address <u>Hyattsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 11, 1957</u> , to <u>Oct 17, 1957</u> , that I last saw the deceased alive on <u>Oct 17, 1957</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. S. Bergeman</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>T. S. Bergeman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Backs sons</u> ADDRESS <u>Hyattsville Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Deedman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

1957 21 OCT

RECEIVED

CERTIFICATE OF DEATH

11078

Reg. Dist. No.

11045

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. LENGTH OF STAY IN 1b 15 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Virginia Middle Slater Last				4. DATE OF DEATH Month Oct Day 9 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-75	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Henry Oden				14. MOTHER'S MAIDEN NAME Josephine Harding			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Daughter		Address Hyattsville, Md	
				Mrs. Norman Fletcher		3910 Livingston Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease DUE TO (c) vascular disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept 1957 , to Oct 1957 , that I last saw the deceased alive on 10-8-57 , 19 57 , and that death occurred at 8:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.L. Etienne				M.D. 4713 Berning Rd DATE SIGNED 10-9-57			
PHYSICIAN'S NAME (Type) W.L. ETIENNE				College Park, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 10/12/57		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Masoleum		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 11 '57	
				24b. REGISTRAR'S SIGNATURE DeLeon			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
				</																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11046

CERTIFICATE OF DEATH

11079

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <i>Pr. Geo.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b <i>3 DAYS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Beland Memorial</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5100 Berwyn Rd.	
3. NAME OF DECEASED (Type or print) First <i>AMER</i> Middle <i>Curtis</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>10</i> Day <i>5</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-23-72</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>CURTIS SMITH</i>		14. MOTHER'S MAIDEN NAME <i>REBECCA GODDARD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service) <i>NONE</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>hosp. records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DEHYDRATION, secondary to</i> <i>571.1</i> DUE TO <i>old Gastro-enteritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>UREMIA</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept</i> , 1957, to <i>Oct</i> , 1957, that I last saw the deceased alive on <i>Oct 4</i> , 1957, and that death occurred at <i>12 P.M.</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>4713 - Berwyn Rd College Park, Md</i> DATE SIGNED <i>10-5-57</i>	
ACTUAL SIGNATURE <i>W.L. Etienne</i>		M.D. <i>W.L. Etienne</i>	
PHYSICIAN'S NAME (Type) <i>W.L. ETIENNE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>10/5/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wat Lincoln Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Roller Manor, Prince Georges Co, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co - Riverdale, Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>OCT 9 1957</i>		24b. REGISTRAR'S SIGNATURE <i>James Henry</i>	

CERTIFICATE OF DEATH

11040

1. NAME OF DECEASED MRS. J. M. [illegible]		2. PLACE OF DEATH [illegible]	
3. DATE OF DEATH [illegible]		4. TIME OF DEATH [illegible]	
5. SEX F		6. AGE [illegible]	
7. OCCUPATION [illegible]		8. CAUSE OF DEATH [illegible]	
9. PLACE OF BIRTH [illegible]		10. DATE OF BIRTH [illegible]	
11. MARITAL STATUS [illegible]		12. EDUCATION [illegible]	
13. PREVIOUS ILLNESS [illegible]		14. MEDICAL HISTORY [illegible]	
15. SIGNATURE OF PHYSICIAN [illegible]		16. SIGNATURE OF REGISTRAR [illegible]	
17. SIGNATURE OF WITNESS [illegible]		18. SIGNATURE OF WITNESS [illegible]	
19. SIGNATURE OF WITNESS [illegible]		20. SIGNATURE OF WITNESS [illegible]	
21. SIGNATURE OF WITNESS [illegible]		22. SIGNATURE OF WITNESS [illegible]	
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59. SIGNATURE OF WITNESS [illegible]		60. SIGNATURE OF WITNESS [illegible]	
61. SIGNATURE OF WITNESS [illegible]		62. SIGNATURE OF WITNESS [illegible]	
63. SIGNATURE OF WITNESS [illegible]		64. SIGNATURE OF WITNESS [illegible]	
65. SIGNATURE OF WITNESS [illegible]		66. SIGNATURE OF WITNESS [illegible]	
67. SIGNATURE OF WITNESS [illegible]		68. SIGNATURE OF WITNESS [illegible]	
69. SIGNATURE OF WITNESS [illegible]		70. SIGNATURE OF WITNESS [illegible]	
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73. SIGNATURE OF WITNESS [illegible]		74. SIGNATURE OF WITNESS [illegible]	
75. SIGNATURE OF WITNESS [illegible]		76. SIGNATURE OF WITNESS [illegible]	
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87. SIGNATURE OF WITNESS [illegible]		88. SIGNATURE OF WITNESS [illegible]	
89. SIGNATURE OF WITNESS [illegible]		90. SIGNATURE OF WITNESS [illegible]	
91. SIGNATURE OF WITNESS [illegible]		92. SIGNATURE OF WITNESS [illegible]	
93. SIGNATURE OF WITNESS [illegible]		94. SIGNATURE OF WITNESS [illegible]	
95. SIGNATURE OF WITNESS [illegible]		96. SIGNATURE OF WITNESS [illegible]	
97. SIGNATURE OF WITNESS [illegible]		98. SIGNATURE OF WITNESS [illegible]	
99. SIGNATURE OF WITNESS [illegible]		100. SIGNATURE OF WITNESS [illegible]	

RECEIVED
OCT 9 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11081
CERTIFICATE OF DEATH11081/3
Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY Prince William <i>George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MITCHELLVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 2232 N. Kentucky St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First Henry Middle Smith Last		4. DATE OF DEATH October 8, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1871
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ebin R. Smith		14. MOTHER'S MAIDEN NAME Mary S. Polley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Myrtle Earnshaw, Mitchellville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201x DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491x (b) Hody King Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis of Heart Disease Generalized Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/13, 1957, to 10/8, 1957, that I last saw the deceased alive on 10/5, 1957, and that death occurred at 9:50 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 10/8/57	
PHYSICIAN'S NAME (Type) H. James Kurtz			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Oct. 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY Maury Cemetery		22d. LOCATION (City, town, or county) (State) Richmond, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Lusk Mrs.		ADDRESS 2847 Wilson Blvd. Arlington, Va.	
24a. REC'D BY REGISTRAR DATE 10-9-57		24b. REGISTRAR'S SIGNATURE Ben M. Anderson	

CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED <i>John Henry Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15 1892</i>	
5. PLACE OF BIRTH <i>Worcester, Mass.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Dec 10 1915</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MEDICAL HISTORY <i>None</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
13. SIGNATURE OF DECEASED <i>John Henry Smith</i>		14. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
15. SIGNATURE OF DECEASED <i>John Henry Smith</i>		16. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
17. SIGNATURE OF DECEASED <i>John Henry Smith</i>		18. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
19. SIGNATURE OF DECEASED <i>John Henry Smith</i>		20. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
21. SIGNATURE OF DECEASED <i>John Henry Smith</i>		22. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
23. SIGNATURE OF DECEASED <i>John Henry Smith</i>		24. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
25. SIGNATURE OF DECEASED <i>John Henry Smith</i>		26. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
27. SIGNATURE OF DECEASED <i>John Henry Smith</i>		28. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
29. SIGNATURE OF DECEASED <i>John Henry Smith</i>		30. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
31. SIGNATURE OF DECEASED <i>John Henry Smith</i>		32. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
33. SIGNATURE OF DECEASED <i>John Henry Smith</i>		34. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
35. SIGNATURE OF DECEASED <i>John Henry Smith</i>		36. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
37. SIGNATURE OF DECEASED <i>John Henry Smith</i>		38. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
39. SIGNATURE OF DECEASED <i>John Henry Smith</i>		40. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
41. SIGNATURE OF DECEASED <i>John Henry Smith</i>		42. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
43. SIGNATURE OF DECEASED <i>John Henry Smith</i>		44. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
45. SIGNATURE OF DECEASED <i>John Henry Smith</i>		46. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
47. SIGNATURE OF DECEASED <i>John Henry Smith</i>		48. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
49. SIGNATURE OF DECEASED <i>John Henry Smith</i>		50. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
51. SIGNATURE OF DECEASED <i>John Henry Smith</i>		52. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
53. SIGNATURE OF DECEASED <i>John Henry Smith</i>		54. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
55. SIGNATURE OF DECEASED <i>John Henry Smith</i>		56. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
57. SIGNATURE OF DECEASED <i>John Henry Smith</i>		58. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
59. SIGNATURE OF DECEASED <i>John Henry Smith</i>		60. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
61. SIGNATURE OF DECEASED <i>John Henry Smith</i>		62. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
63. SIGNATURE OF DECEASED <i>John Henry Smith</i>		64. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
65. SIGNATURE OF DECEASED <i>John Henry Smith</i>		66. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
67. SIGNATURE OF DECEASED <i>John Henry Smith</i>		68. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
69. SIGNATURE OF DECEASED <i>John Henry Smith</i>		70. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
71. SIGNATURE OF DECEASED <i>John Henry Smith</i>		72. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
73. SIGNATURE OF DECEASED <i>John Henry Smith</i>		74. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
75. SIGNATURE OF DECEASED <i>John Henry Smith</i>		76. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
77. SIGNATURE OF DECEASED <i>John Henry Smith</i>		78. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
79. SIGNATURE OF DECEASED <i>John Henry Smith</i>		80. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
81. SIGNATURE OF DECEASED <i>John Henry Smith</i>		82. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
83. SIGNATURE OF DECEASED <i>John Henry Smith</i>		84. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
85. SIGNATURE OF DECEASED <i>John Henry Smith</i>		86. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
87. SIGNATURE OF DECEASED <i>John Henry Smith</i>		88. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
89. SIGNATURE OF DECEASED <i>John Henry Smith</i>		90. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
91. SIGNATURE OF DECEASED <i>John Henry Smith</i>		92. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
93. SIGNATURE OF DECEASED <i>John Henry Smith</i>		94. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
95. SIGNATURE OF DECEASED <i>John Henry Smith</i>		96. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
97. SIGNATURE OF DECEASED <i>John Henry Smith</i>		98. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	
99. SIGNATURE OF DECEASED <i>John Henry Smith</i>		100. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith</i>	

BUREAU V. B.

OCT. 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11047

CERTIFICATE OF DEATH

11081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6708 14th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche T. Cole Snow		4. DATE OF DEATH Month Day Year October 1 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 7 75
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier- Woodward & Lothrop Store		10b. KIND OF BUSINESS OR INDUSTRY W. Virginia	
11. BIRTHPLACE (State or foreign country) U. S.A.		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Arious Nye Cole		14. MOTHER'S MAIDEN NAME Zidena Keller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph C. Cole-Arlington, Va.		Address 44 S. Aberdeen St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heurterholt, gasper-ventral chest		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-22 , 19 57 , to Oct , 19 57 , that I last saw the deceased alive on Oct 1 , 19 57 , and that death occurred at 8:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4713 - Barney Rd College Park, Md. DATE SIGNED 10-2-57		21. ACTUAL SIGNATURE Dr. Walcott Etienne M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/57	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR DATE Oct 3 '57	
24b. REGISTRAR'S SIGNATURE Alfred...			

MAY 1960 STATE DEPARTMENT OF HEALTH-BALTIMORE 15

OCT 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11082

11048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 48 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MATHILDA (N.M.N.) SOHL				4. DATE OF DEATH Month Day Year October 21st, 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15th, 1886		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Stapleton Staten Island, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Mertens				14. MOTHER'S MAIDEN NAME Louise (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 153-09-6139B		17. INFORMANT Address Oliver A. Sohl, 5912 Jefferson St. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiovascular 450.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 18th, 19 57 , to Oct. 21st, 19 57 , that I last saw the deceased alive on Oct. 21st, 19 57 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Deitz				ADDRESS (Street, city or town, state) DATE SIGNED 10/21/57			
PHYSICIAN'S NAME (Type) A. Deitz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE OCT 29 57		24b. REGISTRAR'S SIGNATURE Quench	

OCT 29 1957

RECEIVED

11081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11083

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meadows</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meadows</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosaryville Road</u>				d. STREET ADDRESS <u>Rosaryville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Allen</u> Last <u>Spencer</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>72 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Katie Spencer same as #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 14, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke Meth. Church Ceme.</u>		22d. LOCATION (City, town, or county) (State) <u>Meadows Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>				ADDRESS <u>30 H Street, N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 16 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Reese</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

OCT 16 1957

RECEIVED

11084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4707 Edmonston Road	
3. NAME OF DECEASED (Type or print) George Anthony Stavrakas		4. DATE OF DEATH October 7, 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-57
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antonio Stavrakas		14. MOTHER'S MAIDEN NAME Katherine Blair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Father; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 923.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Suffocation (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coryza			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suffocation in bed while suffering from coryza.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10-7- 19 57 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED October 7, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/57	
22c. NAME OF CEMETERY OR CHURCH Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR OCT 11 57		24b. REGISTRAR'S SIGNATURE Qu...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 11 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10980
CERTIFICATE OF DEATH

11085
245

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5809-44th. Ave.		d. STREET ADDRESS 5809-44th. Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANGELO (N.M.N.) STEFANELLI		4. DATE OF DEATH Month Day Year October 10 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker		10b. KIND OF BUSINESS OR INDUSTRY Lackawana R.R.	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvatore V. Stefanelli		14. MOTHER'S MAIDEN NAME Rosa Vallerine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. 714-01-3921	
17. INFORMANT Address Cornelia Stefanelli 5809-44th. Ave. Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x DUE TO Cardiac arrest of Rhythmic Disturbance. (b) DUE TO Myocardial Infarction. (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10, 1957, to Oct 10, 1957, that I last saw the deceased alive on Oct 10, 1957, and that death occurred at 11:57 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert E. Winters M.D.		DATE SIGNED October 11 - 1957	
PHYSICIAN'S NAME (Type) ROBERT E. WINTERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) Suitland Pk Co, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 5801-CLEVELAND AVE. RIVERDALE MD.		24a. REC'D BY REGISTRAR DATE OCT 15 1957	
24b. REGISTRAR'S SIGNATURE James Leroy			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

BUREAU OF THE ARMY

1957 15 OCT

RECEIVED

CERTIFICATE OF DEATH

11086
Reg. Dist. No.

11083

1. PLACE OF DEATH a. COUNTY <u>Prince George Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills Rural</u>				c. LENGTH OF STAY IN 1b <u>18 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5575 Fisher Rd S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Willard Takmon</u>				4. DATE OF DEATH Month Day Year <u>October 27 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Takmon</u>				14. MOTHER'S MAIDEN NAME <u>Divine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I.</u>				16. SOCIAL SECURITY NO. <u>723-18-1878</u>			
17. INFORMANT <u>Annie Takmon</u>				Address <u>5575 Fisher Rd S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Infarct</u> DUE TO (c) <u>Left Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hours</u> <u>4 yrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Femoral Thrombosis 7 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 1953</u> , to <u>October 1957</u> , that I last saw the deceased alive on <u>October 20 1957</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Anna Coyne Todd</u> M.D. <u>7519 Broadview Rd S.E. D.C. 22</u> <u>10/27/57</u>							
ACTUAL SIGNATURE <u>ANNA COYNE TODD</u> 7519 Broadview Rd S.E. D.C. 22							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1661 Good Hope Road S.E. Washington 20, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 29 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-104

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11087
Reg. Dist. No.

11050

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4803 R Street SE	
3. NAME OF DECEASED (Type or print) Carl Franklin Jeter		4. DATE OF DEATH Oct 5 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH June 21, 1893	9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt	11. BIRTHPLACE (State or foreign country) Missouri
13. FATHER'S NAME Franklin Jeter		14. MOTHER'S MAIDEN NAME Marietta Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel G Jeter, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct 5, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 10-5-1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Pk. Geo. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Sommers Bros. 1661 Good Hope Rd SE		DATE OCT 7 '57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 28
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1104

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]

BUREAU V. E.

OCT 2 1957

RECEIVED

11084

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES, MARYLAND MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE, MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSPITAL				d. STREET ADDRESS 2515 15TH ST., N.W. APT. # 318			
3. NAME OF DECEASED (Type or print) JAMES M. THOMPSON				4. DATE OF DEATH Month OCTOBER Day 19 Year 19 57			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 22, 1901		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTRUCTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) RICHMOND, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIS H. THOMPSON				14. MOTHER'S MAIDEN NAME LUCY SCOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 709-12-4802		17. INFORMANT DECEASED			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA WITH WIDESPREAD METASTASIS, PRIMARY SITE KIDNEY, LEFT 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT NEPHRECTOMY 6/57						INTERVAL BETWEEN ONSET AND DEATH 5 MOS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/27 , 19 57 , to 10/19 , 19 57 , that I last saw the deceased alive on 10/19 , 19 57 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. H. Weiss M.D. GLENN DALE HOSPITAL, GLENN DALE, MD. 10/19/57							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		10/19/57		Lincoln Mem. Cemetery		Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McElhiney				ADDRESS 1820 9th St NW		24a. REC'D BY REGISTRAR DATE 10/22/57	
						24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL RESERVE	
M.D.		DATE	
JAN 10 1957		JAN 10 1957	

BUREAU Y. R.

JAN 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11089

Reg. Dist. No.

248

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southland x2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4697-Homer Ave</u>				d. STREET ADDRESS <u>4697-Homer Ave</u>			
3. NAME OF DECEASED (Type or print) <u>William Wentworth Thornton</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Special</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jack Thornton</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Charles F Thornton</u> Address <u>3815-75th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>-3004 N. 4</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
 OCT 18 1957
 BUREAU V. 1

11051
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11090

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN 1b <u>18 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>4626 42nd Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>W.</u> Last <u>TISE</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-74</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post master</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George W. Tise</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Wallis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Hospital Records Cherry, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoid mesenteric</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal Obstruction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> <u>2 wks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald W. Mitchell</u>				ADDRESS (Street, city or town, state) <u>1746 H St NW, Wash DC</u>			
DATE SIGNED <u>10/28/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Snacka Sons Hyattsville Md</u>				24a. REC'D BY REGISTRAR <u>DATE 28 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Rehman</u>	

BUREAU V. 5

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11052

CERTIFICATE OF DEATH

Reg. Dist. No.

11091

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN 1b 49 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Lanham Md				d. STREET ADDRESS 1 4th & D Streets			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Clara Tomczak				4. DATE OF DEATH Month Day Year Oct 7 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26th, 1892		9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Scranton, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stankiewicz				14. MOTHER'S MAIDEN NAME Mary Niazolkiwcz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Stanley J. Tomczak, Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic CA of Pelvis 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 31 19 57 to Oct 7 19 57 , that I last saw the deceased alive on Oct 8 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. C. Hageage				M.D. 3308 Perry St, Mt. Rainier DATE SIGNED 10/7/57			
PHYSICIAN'S NAME (Type) C. C. Hageage M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/1957		22c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		22d. LOCATION (City, town, or county) (State) Riggs Rd. Extd. Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chamber Co				ADDRESS Riverdale, Md.		24a. RECEIVED BY REGISTRAR W W Chamber DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11092

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4900-52nd Place				d. STREET ADDRESS 4900-52nd Place			
3. NAME OF DECEASED (Type or print) First LLOYD Middle A. Last TRAFTON				4. DATE OF DEATH Month October Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28, 1903	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Steward		10b. KIND OF BUSINESS OR INDUSTRY Capital Fabrics Club		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME alvin J. Trafton			
14. MOTHER'S MAIDEN NAME Ida Pinkerton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 213-01-8637				17. INFORMANT Address above Barbara A. Hedding, Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of Rectum (c) About 6 mo INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from April 5, 1957, to Oct 8, 1957, that I last saw the deceased alive on Oct 7, 1957, and that death occurred at 530 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Reason M.D.				ADDRESS (Street, city or town, state) 5304 Annapolis Rd. Bladensburg, Md.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/10/57		22c. NAME OF CEMETERY OR CREMATORY Washington National	
22d. LOCATION (City, town, or county) Suitland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE OCT 11 '57	
24b. REGISTRAR'S SIGNATURE							

BUREAU V. 8

OCT 11 1957

RECEIVED

10981

CERTIFICATE OF DEATH

11093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE.</u>				c. LENGTH OF STAY IN 1b <u>16 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 W. HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONV. HOME.</u>				d. STREET ADDRESS <u>12516 AVALON PL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GILBERT</u> Middle <u>W.</u> Last <u>UPTON</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 16 1867</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BLACKSMITH</u>		11. BIRTHPLACE (State or foreign country) <u>W - VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SYLVESTER UPTON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. Sybil Simmons (Wg)</u> Address <u>Records - Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10-12 years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 1956</u> , to <u>Oct. 27, 1957</u> , that I last saw the deceased alive on <u>Oct. 20, 1957</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u> M.D. <u>1806 FOX ST. Hyattsville, Md.</u>				DATE SIGNED <u>10/27/57</u>			
PHYSICIAN'S NAME (Type) <u>James L. Laubach, M.D.</u> <u>1806 FOX ST. Hyattsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 29 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WILD WOOD</u>		22d. LOCATION (City, town, or county) (State) <u>Beekley W. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. TALTAVULL</u> ADDRESS <u>3603 14th St NW</u>				24a. REC'D BY REGISTRAR <u>OCT 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James L. Laubach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10041

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

File No. 10

Place of Death

Residence

Place of Birth

Age

Sex

Color

Height

Weight

Build

Complexion

Scars

Other

Signature

Date

Time

Place

Signature

Date

Time

Place

Signature

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BUREAU V. 2

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11094240
Reg. Dist. No. 109

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>11 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #1 Box 14</u>				d. STREET ADDRESS <u>Route #1 Box 14</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Wilmer Watson</u>				4. DATE OF DEATH Month Day Year <u>Oct 16 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1897</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marble Job</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jeremiah Watson</u>				14. MOTHER'S MAIDEN NAME <u>Mally Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Mrs Joseph W Watson,</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound of head</u> (c) <u>gun shot wound of head</u> DUE TO cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in right temporal area</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>10-16 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Brandywine PG Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Meth. com.</u>		22d. LOCATION (City, town, or county) (State) <u>Horsehead, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT Funeral Home</u>				ADDRESS <u>WALDORE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>10/22/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. E. E. E.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11088

CERTIFICATE OF DEATH

11095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. STREET ADDRESS 3541 - 10'th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alton Middle Lee Last Williams		4. DATE OF DEATH Month Oct. Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/21
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Williams		14. MOTHER'S MAIDEN NAME Peary Lee Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-14-8953	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 16 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 30 , 19 57 , to October 3 , 19 57 , that I last saw the deceased alive on October 3 , 19 57 , and that death occurred at 3:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss		DATE SIGNED 10/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-8-1957		22b. DATE THEREOF 10-8-1957	
22c. NAME OF CEMETERY OR CREMATORY Norwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines + Co.		24a. REC'D BY REGISTRAR OCT 8 '57	
ADDRESS 901-3rd St. S.E.		24b. REGISTRAR'S SIGNATURE Paul Smith	

BUREAU V. S.

OCT 8 1957

RECEIVED